

Beat the Stigma and Discrimination!

Four Lessons for Mental Health Advocates

Beat the Stigma and Discrimination! is written for the busy advocate who yearns for strategies that will advance the mental health agenda. It largely focuses on "how to" and not "why." It focuses on correcting the disparity and increasing both opportunities and resources for people with mental illness.

Many of the problems confronting people with mental illness result from public misunderstanding about psychiatric disorders. At the most harmful levels, these misunderstandings rob people of rightful life opportunities. At more benign levels, they result in a failure to prioritize mental health issues in the political arena. In either case, public ignorance translates to stigma, prejudice, and discrimination that permeate common assumptions about mental illness and undermines equal opportunities.

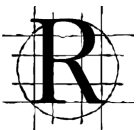
Although the ideas represented in *Beat the Stigma and Discrimination!* reflect extensive research conducted by social scientists, it is meant to be a practical guide. Hence, it is not loaded with theory, concepts, and citations. It is also meant to be a brief outline of concrete issues rather than a lengthy treatise on abstract concepts.

Strategies that accomplish these goals vary from the hammer that demands righteous change to the glove that seeks partners who will promote this kind of evolution. Choice of hammer or glove depends on accurate understanding of the problem. I view the problems wrought by stigma, and the solutions brought by advocacy, as social and psychological processes. The advocate's goal is to change attitudes about and beliefs towards people with mental illness. This can be done effectively and strategically by understanding the social and psychological factors that influence the way people act. *Beat the Stigma and Discrimination!* is a valuable tool in pursuit of this strategy.

- Patrick W. Corrigan, Psy.D.

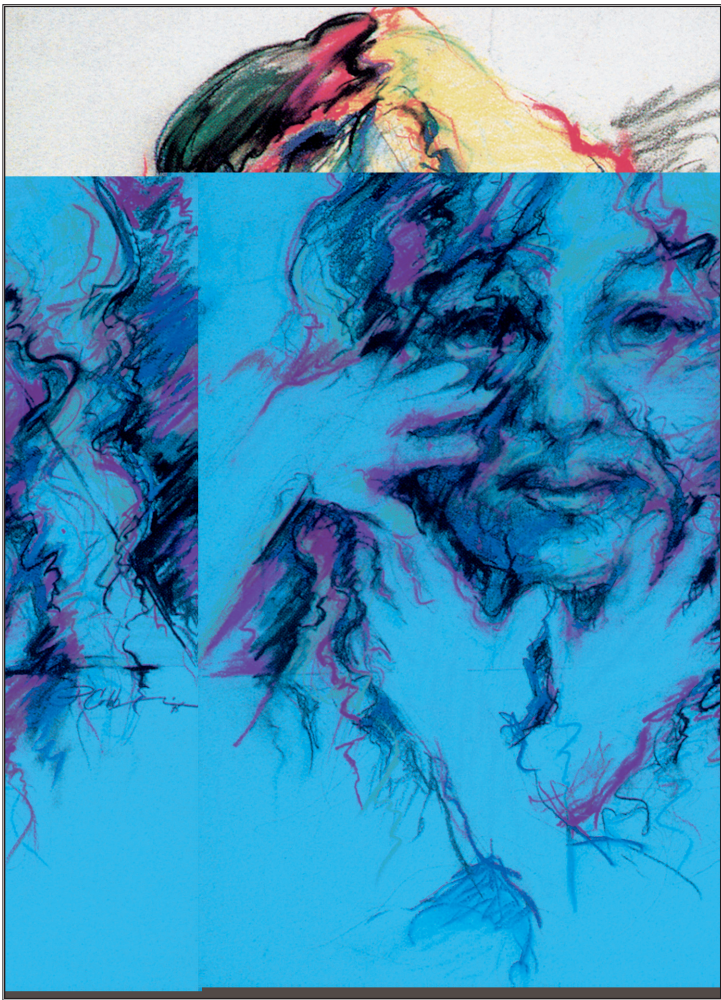
About Patrick Corrigan

Patrick Corrigan has been struggling successfully with bouts of major depression for more than 25 years. He spent the first 14 years of his career at the University of Chicago where he directed the Center for Psychiatric Rehabilitation. In 2004, he and the Center moved to Northwestern University, where Dr. Corrigan is Professor of Psychiatry and Psychology, and to Evanston Northwestern Healthcare where he directs the Center for Psychiatric Rehabilitation. The Center is a research and training program dedicated to the needs of people with serious mental illness and their families. Corrigan has been principal investigator of federally funded studies on vocational rehabilitation, team leadership, and consumer-operated services. Four years ago, Corrigan became principal investigator of the Chicago Consortium for Stigma Research (CCSR), the only NIMH-funded research center examining the stigma of mental illness. Among other projects currently related to stigma, Corrigan is principal investigator of a multi-national study on employers and stigma in Beijing, Hong Kong, and Chicago. Corrigan is a prolific researcher having published more than 200 papers and ten books, including *Don't Call Me Nuts! Coping with the Stigma of Mental Illness*, co-authored with Bob Lundin. Corrigan is married to Georgeen Carson, a Cook County public defender and together they raise their two children, Abe and Liz, in the North suburbs of Chicago.

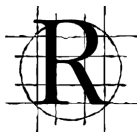


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Art on the front cover: “Queen of Fools,” 18” x 24” pastel self-portrait, by the late Trish Evers.

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PREFACE: WHERE THIS HANDBOOK FALLS ON THE SCOPE OF ADVOCACY

Psychiatric disabilities had forced him in and out of the hospital for most of his adult life, but still Henry Johnson was ready for work. His job coach got him an interview at a local convenience store where several listings had just been posted for part-time clerks. Unfortunately, once Ms. White, the store manager discovered big gaps in Henry's work history – times he was in a state hospital – she said no positions were currently available.

While addressing a professional meeting of psychiatrists, Deborah Black, a local state legislator, announced that she was fully in support of community-based psychiatric services. Unfortunately, she said that other pressing public health priorities prevented her from supporting an increase in the mental health budget for the next fiscal year. Moreover, she signed off on legislation that decreased the rights of a person diagnosed with a mental illness in family court.

Many of the problems confronting people with mental illness result from public misunderstanding about psychiatric disorders. At the most harmful levels, these misunderstandings rob people of rightful life opportunities. At more benign levels, they result in a failure to prioritize mental health issues in the political arena. In either case, the *disparity* between what is available and what is provided to people with mental illness is significant and motivates the advocate to change the existing state of affairs. Many barriers cause this disparity; prominent among these is inaccurate knowledge, understanding, and perception of people, their mental illnesses, and the breadth of services available to help them. Public ignorance translates to stigma, prejudice, and discrimination that permeate common assumptions about mental illness and undermines equal opportunities.

This handbook focuses on correcting the disparity and increasing both opportunities and resources for people with mental illness by reviewing ways in which negative public attitudes might be reduced and more appropriate attitudes might be enhanced. Strategies that accomplish these goals vary from the hammer that demands righteous change to the glove that seeks partners who will promote this kind of evolution. Choice of hammer or glove depends on accurate understanding of the problem. I view the problems wrought by stigma, and the solutions brought by

advocacy, as social and psychological processes. The advocate's goal is to change attitudes about and beliefs towards people with mental illness. This can be done effectively and strategically by understanding the social and psychological factors that influence the way people act.

Stigma does not mean a moral term, but rather refers to the attitudes and behavior that everyone learns about minority groups (like people with mental illness) which some people then use to intentionally or unintentionally block the life opportunities of people with mental illness.

Although the ideas represented in this handbook reflect extensive research conducted by social scientists, it is meant to be a practical guide. Hence, it is not loaded with theory, concepts, and citations. It is also meant to be a brief outline of concrete issues rather than a lengthy treatise on abstract concepts. The handbook is written for the busy advocate who yearns for strategies that will advance the mental health agenda. It largely focuses on “how to” and not “why.” It ends with a brief introduction to the Chicago Consortium for Stigma Research for the reader interested in further learning about the empirical underpinnings of many of the assertions made in this handbook.

The Best Advocacy Is Targeted and Local

Much of the adult population endorses some of the prejudice associated with mental illness, discriminates against people who are labeled mentally ill, and ends up blocking opportunities or resources for people with mental illness. The population as a whole, however, is a terrible target for stigma-reduction; it's everyone! “Everyone” is such a diverse group of people that crafting an effective strategy for it is nearly impossible. Moreover, although everyone might be involved, specific groups by nature of their relationships with individuals with mental illness have significant power to block the mental health advocacy agenda, or for that matter, to move it forward. Examples of power groups include:

- Employers who might hire people with mental illness;
- Landlords who might provide housing to people with mental illness;
- Police who might encounter a person with mental illness at a crime scene;
- Health care providers who have to decide what treatment is best to serve the person's diverse physical and mental health problems; and
- Legislators who must decide how to allocate funds for mental health programs and whether to enact statutes that directly impact the lives of people with mental illness.

Advocacy programs are most effective when targeting people in these roles.

To paraphrase a past speaker of the U.S. House of Representatives, the most effective advocacy agendas and stigma-reduction programs, like the best politics, are LOCAL. Members of the same community tend to develop a shared perspective on the world, a perspective that influences collective notions about mental illness. Local people share a vocabulary and points of view. Hence, advocates need to target a key power group within well-defined communities, with what is meant by “community” defined broadly. They must try to:

- Get all the employers in Bloomington to hire people with mental illness;
- Get all officers in the Austin neighborhood of Chicago to use mental health programs when working with crime-involved individuals with psychiatric disabilities;
- Get all doctors in a large provider network to improve their practice for people with mental illness;
- Get landlords in suburban DuPage County to promote more rental accommodations for individuals with mental illness; and
- Get all state legislators to support an expanded mental health funding bill.

The Four Lessons

Most advocates typically work on multiple projects to enhance opportunities and resources for people with mental illness. They may be trying to get the legislature to increase its mental health budget or support a parity bill. They may be educating employers so that they hire more people with mental illness. They may be concentrating on landlords and their pattern of renting to people with mental illness. Many projects require years of focus and energy. Others are relatively short-term affairs created to address a well-defined agenda. This handbook provides a pragmatic guide for the mental health advocate approaching a specific social change project. The handbook is based on four straightforward questions:

1. *What is the problem?* How do stigma, prejudice, and discrimination block the achievement of major advocacy goals? What do we hope will be accomplished so that better services or more opportunities are available to people with mental illness?

The mental health advocates' agenda is best described as a collection of goals that will be accomplished via a series of discrete projects. Accomplishing these projects in part requires tearing down the prejudice and discrimination of mental illness that blocks them

2. *Who are the targets?* Typically, a group of people is targeted for change (e.g., employers in the community, legislators at the capital, primary care

doctors at the hospital). Advocates who focus on local power groups are likely to be the most effective. Who has the power to block what you want?

3. *What are the change strategies?* What will advocates specifically do to accomplish their goals with these target groups?

4. *Did the project have any impact?* How will advocates know that their goals were accomplished?

Answers to these questions yield an action plan. In this handbook, we present these questions and corresponding answers as four lessons for the mental health advocate. Completion of these lessons will arm the advocate with skills and information to better accomplish their change projects.

Who Is the Person with Mental Illness in This Handbook?

The answer to this question is complex. Mental illness can vary from relatively mild adjustment disorders, to somewhat moderate anxiety disorders, to fairly severe psychiatric disabilities. Some discussions of mental illness include childhood disorders, developmental disabilities, and substance abuse. People with any of these disabilities can be harmed by discrimination and stigma. Although there is much overlap across groups in the mental health advocacy agenda and the harm wrought by stigma across groups, there are some important differences too. Hence, it is important to understand which segment of the population labeled mentally ill, and which part of the mental health agenda, is the primary focus of this handbook.

The primary focus of this handbook is the mental health agenda of adults with psychiatric disabilities. These are people who, because of serious mental illnesses – e.g., schizophrenia, bipolar disorder, severe depression and anxiety, and some personality disorders – are not able to successfully attain typical goals of adulthood including employment, housing, and relationships. Although their mental health agenda overlaps with those of other psychiatric disorders, it is frequently distinguishable from related disabilities due to developmental disorders (e.g., autism and mental retardation) or substance abuse.

Who Is an Advocate?

Four groups commonly respond to the call for mental health advocacy: people with mental illness, their families, service providers, and civic-minded citizens. People with mental illness are sometimes called consumers (i.e., they consume mental health services). Many consumers are concerned about the quality of services available to them so that they may accomplish the various life goals that are blocked by their symptoms and disabilities. Typically included in this group are survivors and ex-patients, individuals who are troubled by the coercive arm of psychiatry that has added to their loss of rights. Common to all consumer advocates is a focus on empowerment (captured in the consumer battle cry, “NOTHING ABOUT US WITHOUT US!”) and recovery (enjoyment of the full range of life opportunities).

There is no single organization that represents the entire consumer/survivor constituency although the annual Alternatives Conferences (funded by the U.S. Center for Mental Health Services (CMHS) and hosted by various consumer groups) has a long history of bringing diverse groups to a single meeting. CMHS has also funded three consumer-run national technical assistance centers (TACs); at this writing, the TACs have been targeted for cuts by the Bush administration and have only been renewed for a year's funding.

Family groups are also concerned about the quality of services, although their priorities occasionally differ from those of consumer advocates. Family groups want relatives with mental illness to have a full range of services. But they also are concerned about the safety of their relatives, especially those who experience periods during which they may not be fully aware of the extent of their symptoms and disabilities. Hence, some family advocates might support services that may seem coercive to consumers. Family groups, like consumers and survivors, organized in part because of large dissatisfaction with the mental health system. Families were especially frustrated by a long history of mental health professionals excluding them from their relatives' care plan and government officials who turned a deaf ear to their concerns. The chief advocacy group for family members is NAMI (formerly known as the National Alliance for the Mentally Ill).

Most mental health disciplines have corresponding professional associations that seek to promote their priorities. These include the professional organizations representing social workers, nurses, public health administrators, psychiatrists, and psychologists. They have a mixed agenda that encompasses promoting the needs of men and women who are service professionals as well as improving the quality of services they provide.

The various constituencies that comprise mental health advocacy are far apart on some issues, and speak with unified voice on others.

The fourth group of advocates is called "civic-minded citizens" to reflect the long and proud history in America of people who recognize and seek to rectify social problems without necessarily having a vested interest in those problems. The National Mental Health Association (NMHA) is an excellent example of this kind of group with almost a 100-year history of addressing the advocacy needs of citizens with mental illness.

Clearly, these four groups are not of single voice; there is as much diversity of beliefs and behaviors within consumer groups, family organizations, professional associations, and civic-minded citizens as among any other collection of people. Moreover, the boundaries between groups are not black and white. Although NAMI is the dominant family advocacy group in the United States, it has actively sought the

full participation of consumers at all levels of its organization in the past decade. The NMHA may represent a collection of civic-minded citizens but it was begun by Clifford Beers, a former psychiatric patient, and has individual members and leaders who are noted consumer/survivor activists.

On many issues, these four groups agree and together, become a vital force for advocating the corresponding positions. On other issues, however, advocates representing different constituencies stake out opposing positions. In fact, a campaign of one advocacy group might actually find the platform of another being its biggest barrier to success. Hence, advocates need to be aware of the perspective of various constituencies when crafting an action plan for a specific project. When possible, collections of advocates from all four constituencies are likely to have the most power in obtaining resources and opportunities for people with mental illness.

A Final Point About Language

Some advocates and social scientists make the compelling point that language can worsen the social injustices that rob life opportunities from people with mental illness. Hence, it is important for advocates to be aware of the choices they make in referring to their constituencies and the other stakeholder groups. Note, for example, the various terms that refer to the consumer constituency that have been embraced by various factions: ex-patients and survivors to name just two. Generally, this handbook uses person-first language throughout; e.g., people with mental illness or individuals with schizophrenia. Another group label that offers potential problems is “family.” Referring to families who struggle with mental illness may perpetuate two myths that unintentionally support stigma. First, the troubles of families are “caused by the relative with mental illness;” this perpetuates the notion that people with mental illness are somehow to blame for their symptoms and disabilities. Second, labeling one group as “family” members may suggest that people with mental illness are not themselves family. Because they are the identified “patient,” they are unable to fulfill such important roles as parents, spouses, or siblings to others. Identifying the fourth group as civic-minded citizens may create a similar problem. It may suggest that neither people with mental illness nor their families are capable of being concerned about the public good.

There is no easy solution to the problem of how to identify a particular group. Instead, advocates need to be aware of the tension among various labels and be prepared to deal with the anger or misunderstanding that may come from another group when such a label is used.

Lastly, we need to avoid stigmatizing the stigmatizer. Much of this manual asserts that stigmatizing beliefs and discriminatory behavior of key people in power — legislators, business people, health care providers, police officers and legislators — pose major barriers to the lives of people with mental illness and to the advocacy agenda. Hence, targeting the misconceptions caused by stigma is a necessary step in advancing advocate’s goals. Terms like stigma, prejudice, and discrimination evoke perceptions of ignorance, racism, and superiority. They lead to finger pointing and blame.

In some cases, groups of people may elect to stigmatize individuals with mental illness as a planned strategy to advance their agenda. For the most part, however, stigma, prejudice, and discrimination are processes that arise not out of malice, but because of “normal” psychological events. Hence, stigmatizers are not purposefully choosing to be unjust, but rather reacting to their concept of the world. This is an important distinction for the advocate’s work. The goal is not to smite the unjust source of stigma. Rather, the goal is to correct the social and psychological forces that promote stigmatizing views in some people in positions of power. *Smiting* requires anger and force. *Correcting* similarly benefits from anger and force but also needs wisdom and strategy. Avoid the blame game.

LESSON 1: UNDERSTANDING THE PROBLEM

Democracy arose from men's thinking that if they are equal in any respect, they are equal absolutely.- Aristotle

This handbook is based on the assumption that the mental health advocate's agenda is blocked at least partly by public stigma, prejudice, and discrimination. Hence, advocates need to understand from where comes the tendency to stigmatize, and what form it might take. Although researchers have proposed several theories that explain stigma, this handbook largely relies on the rational actor model.

RATIONAL ACTORS: UNDERSTANDING INDIVIDUAL ATTITUDES AND CORRESPONDING BEHAVIORS

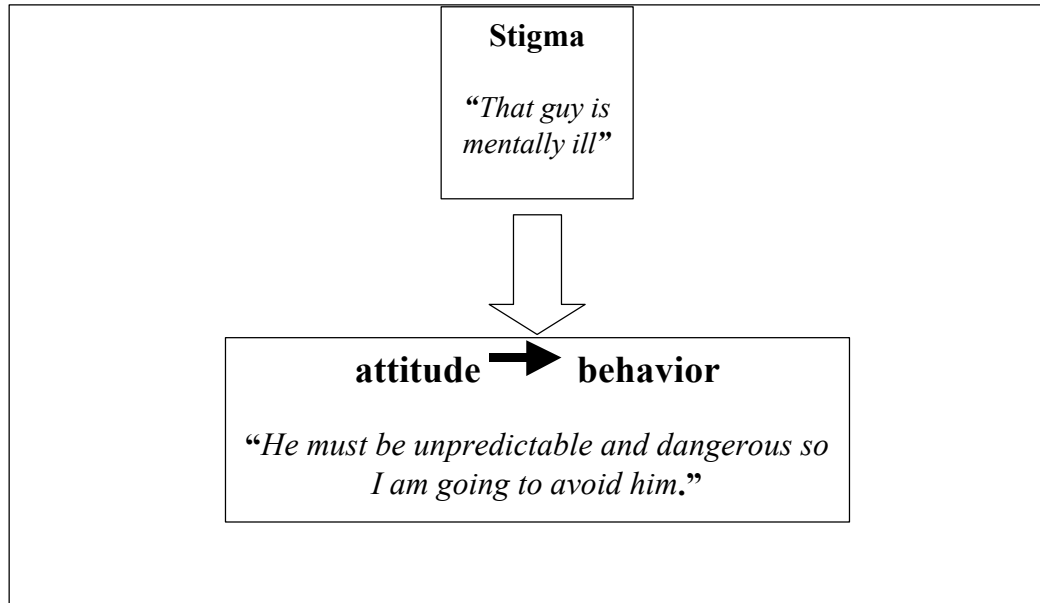
Psychologists have argued for more than a century that humans are fundamentally rational actors; that they behave in specific ways based on their “logical” understanding of the circumstances. Psychologists describe the notion of humans as rational actors with a simple formula:

attitudes → behaviors.

Harry believes Democrats are the better party (attitude) so he voted for Al Gore for President (behavior). Georgeen thinks big dogs are smarter and so she bought a Saint Bernard. Jean thinks Irish Americans are drunks so she turned down a date with her Irish neighbor. Sometimes attitudes about a group are prejudicial and lead to discriminatory behavior. Bob thinks people with mental illness are dangerous so he won't hire anyone who has been in a psych hospital. Hence, achieving advocacy goals depends on changing the attitudes and behaviors of selected people who hold positions of power over the lives of individuals with mental illness.

Stigma is the cue that signals a specific attitude-behavior link (see Table 1). According to sociologist Erving Goffman, stigma is a mark, a sign that somehow discredits the person. These marks have included skin color, physical signs of gender, and body size (signaling obesity). They also may include labels, mean-spirited ways of talking about a group of people; most readers may be able to think of such terms for gays and lesbians, Jews and Catholics, or people with mental illness. Calling a person “mentally ill,” or one of its synonyms, yields the attitudes related to the stigma, which can in turn affect behavior.

Table 1. Stigma, Attitudes, and Behaviors



Note why the link between attitude and behavior is considered rational. Psychologists do not mean to imply that behaving in a hostile manner against a minority group because of some strongly held prejudice is justified. Rather, the link means that one's behaviors rationally follow from one's attitudes. For example, if Jean believes all Irish Americans are violent drunks, then it makes logical sense that she is not going to date an Irishman. Hence, peoples' behaviors toward other people are a function of their attitudes. Generally, individuals will respond positively to others when they hold positive attitudes about them. Conversely, they will react harshly to people or may avoid them altogether when corresponding attitudes are negative. The interaction of positive and negative versions of attitudes and behaviors is outlined in Table 2. Note that discrimination is an alternative term for the behaviors that result from stereotypes.

Negative attitudes about *groups of people* are called stereotypes. As shown in Table 2, research has outlined several stereotypes about people with mental illness. Stereotypes are generally based on myths or grossly exaggerated statements of fact. Perhaps the most pervasive of stereotypes, and the one that is likely to yield the greatest discrimination, is that people with mental illness are *violent or dangerous*. The news media overplays stories of "psychotic killers" or people who "snap after going off their meds." The entertainment industry seems to particularly enjoy this perception because it frequently highlights the "manic killer" in drama series on television or in feature length films. Related to attitudes about dangerousness is *unpredictability*. During periods when people with mental illness have little relief from their psychiatric symptoms, especially those symptoms related to psychoses, the behavior of people with mental illness is thought to be hard to predict. This makes

Table 2. The interaction among positive and negative examples of attitudes and behaviors; this matrix explains how individuals might stigmatize OR think optimistically about people with mental illness.

| Attitudes | | Behaviors | | | | |
|--|---|--|-----------|--|--|--|
| N E G A T I V E | <p><u>Stereotypes</u>: negative beliefs about people with mental illness: <u>Prejudice</u>: emotional reactions that result from endorsing stereotypes</p> <table><tr><th>Stereotypes</th><th>Prejudice</th></tr><tr><td>Dangerousness: <i>because of their mental illness, people are likely to become violent.</i> Unpredictability: <i>their violence is exacerbated by never being able to tell how a person with mental illness will react</i> Incompetence: <i>people with mental illness are unable to live independently or manage anything but the simplest of jobs</i> Childlike: <i>people with mental illness need an authoritarian figure to make decisions for them just like a parent to a child</i> Blame: <i>people with mental illness choose to be sick because of a weak moral backbone</i> Contagion: <i>people who associate with the mentally ill will develop the same kind of symptoms and disabilities</i></td><td>Fear: <i>because they are potentially violent; people with mental illness are frightening</i> Anger: <i>people with mental illness escape many of the responsibilities of adult life and are deserving of public anger</i> Pity: <i>people with mental illness are pitiful</i> Disgust: <i>at a gut level, people with mental illness are repulsive</i></td></tr></table> | Stereotypes | Prejudice | Dangerousness: <i>because of their mental illness, people are likely to become violent.</i> Unpredictability: <i>their violence is exacerbated by never being able to tell how a person with mental illness will react</i> Incompetence: <i>people with mental illness are unable to live independently or manage anything but the simplest of jobs</i> Childlike: <i>people with mental illness need an authoritarian figure to make decisions for them just like a parent to a child</i> Blame: <i>people with mental illness choose to be sick because of a weak moral backbone</i> Contagion: <i>people who associate with the mentally ill will develop the same kind of symptoms and disabilities</i> | Fear: <i>because they are potentially violent; people with mental illness are frightening</i> Anger: <i>people with mental illness escape many of the responsibilities of adult life and are deserving of public anger</i> Pity: <i>people with mental illness are pitiful</i> Disgust: <i>at a gut level, people with mental illness are repulsive</i> | <p><u>Discrimination</u>: negative behaviors that result from stereotypes and prejudice</p> <p>–Coercion: forced treatment</p> <p>–Avoidance: withholding work and independent living opportunities</p> <p>–Low priorities: Provide resources for more deserving people and services first</p> |
| | Stereotypes | Prejudice | | | | |
| Dangerousness: <i>because of their mental illness, people are likely to become violent.</i> Unpredictability: <i>their violence is exacerbated by never being able to tell how a person with mental illness will react</i> Incompetence: <i>people with mental illness are unable to live independently or manage anything but the simplest of jobs</i> Childlike: <i>people with mental illness need an authoritarian figure to make decisions for them just like a parent to a child</i> Blame: <i>people with mental illness choose to be sick because of a weak moral backbone</i> Contagion: <i>people who associate with the mentally ill will develop the same kind of symptoms and disabilities</i> | Fear: <i>because they are potentially violent; people with mental illness are frightening</i> Anger: <i>people with mental illness escape many of the responsibilities of adult life and are deserving of public anger</i> Pity: <i>people with mental illness are pitiful</i> Disgust: <i>at a gut level, people with mental illness are repulsive</i> | | | | | |
| P O S I T I V E | <p><u>Positive expectations</u> about people with mental illness</p> <ul style="list-style-type: none">– Recovery– Real life goals– Empowerment <p>The emotional goal is <u>empathy</u> not sympathy</p> | <p><u>Affirmative actions</u> that promote people with mental illness at all levels of life opportunities</p> <ul style="list-style-type: none">– Reasonable accommodation– Increased funding | | | | |

their potential for violence seem all the more frightening; “even a person with a history of mental illness who looks normal may snap at any moment.”

Incompetence is a third, commonly heard stereotype; people with mental illness are not able to live independently or work at anything other than the most menial job. According to this perspective, the prototypic individual with serious mental illness lives out his or her life on the back wards of state hospitals or wandering the streets homeless. People with serious mental illness who have succeeded at school, obtained good jobs, have a happy family, and live in a nice home are considered exceptions to the rule and not challenges to the idea of incompetence. Closely related to the incompetence stereotype is being childlike, although this

stereotype is more commonly applied to people with mental retardation. According to this stereotype, people with mental illness are innocent, naïve, and incapable of meeting the challenges of everyday life. Hence, decisions need to be made by a parent or other authority because they are unable to make informed choices for themselves.

Two other stereotypes emerge from research. The first is blame; namely, that because of weak moral backbone, people with mental illness choose symptoms and disabilities rather than face the demands of modern life. This stereotype is especially common among members of the general population who endorse the Protestant work ethic. “Pull yourself up by your bootstraps; those who do not are choosing to turn their backs on life’s opportunities.” Finally, contagion is a widespread and troubling stereotype. Members of the general public who hold this view believe they can become mentally ill by associating with individuals with psychiatric disorders. Some people worry they can catch mental illness like a germ while others are concerned about moral infection; “hanging out with morally weak mentally ill people may make me or my children morally weak.” Contagion can be an especially troubling stereotype for family members and leads the public to avoid and otherwise abandon those with mental illness.

There are several different stereotypes about people with mental illness that lead to discrimination. Remember, stereotypes are myths, built on inaccurate information or perceptions.

Stereotypes and Prejudice

Researchers frequently distinguish between stereotypes and prejudice. Stereotypes are thoughts about a group. Prejudice is agreement with those thoughts plus the resulting emotional reaction. In their purest form, stereotypes are nothing more than statements about a group that we have all heard before. Most Americans can provide a list of stereotypes about various ethnic groups; e.g., Irish American men are heavy drinkers who abandon family responsibilities. Agreeing with the stereotype is prejudice – “that’s right, Irish American men are all drunks” – which yields a strong emotional reaction – “and Irishmen all anger me because of their weak constitution and the suffering they cause their families.” Table 2 includes four emotional reactions that commonly result from agreeing with the stereotypes about mental illness.

Given that dangerousness may be among the most damaging and prevalent of stereotypes, it is no surprise that *fear* may be the most common and problematic of emotional reactions. Much of the general public is afraid of people with mental illness. Fear leads to avoidance to protect one’s self. Danger, and the belief that people are responsible for their mental illness may also lead to *anger*. Many people resent individuals with mental illness, believing they can get away with temper

tantrums while most of the population needs to restrain themselves and act like “adults.” Viewing people with mental illness as childlike can yield *pity* as well as anger. Frequently, pity or sympathy seems to be an example of positive emotional reactions, not necessarily a reflection of prejudice. Viewing someone as pitiful, however, is often the rationale for disempowering people with mental illness. “It is so sad that the person is unable to care for herself but luckily the doctor can make all the decisions about what is best.” Surveys show the combination of pity and disempowerment are of major concern to mental health consumers and other advocates. Disgust commonly occurs as the result of any of the stereotypes. Namely, some members of the general public respond negatively to people with a mental illness at a gut level. This primary emotional reaction can lead to strong discriminatory responses.

The Discrimination that Results from Stereotypes and Prejudice

As shown in Table 2, discriminatory behaviors fall into three categories: avoidance, coercion, and lowered priorities. People who believe some of the stereotypes about individuals with mental illness (e.g., that they are dangerous, unpredictable, and incompetent) are likely to avoid them. In addition to a general avoidance of people who seem “mentally ill” on the street, this kind of discrimination may appear in work settings (e.g., employers do not hire people with mental illness so they can be avoided), housing (landlords do not lease to people with mental illness so that other renters are not bothered by them), and houses of worship (pastors do not fully welcome people with mental illness in order to prevent alienating other members of the congregation).

Agreeing with stereotypes is likely to also lead to coercion that often appears in subtle forms. The public frequently endorses mandated treatments for people with mental illness; they believe these people are not capable of making fully informed decisions about their treatment so they sometimes should be forced into “care.” This may include forced medication and inpatient hospitalization. Segregation often appears as an adjunct to coercion. The public may believe that treatment programs should be in asylums that are far removed from the person’s home and community. Finally, legislatures often support coercive measures through the statutes they enact. Research has shown that about a third of the states in the union have laws on the books that in some way restrict civil rights (voting, jury duty, running for office) and family matters (divorce, child custody, and adoption) because a person has been identified as “mentally ill.”

Perhaps the subtlest form of discrimination is passive. Namely, community needs of people with mental illness are not high priority. For example, advocates must remember that the priorities for which they seek support are only a few on a long list of issues which people in power must address. Advocates seeking more funds for the mental health system have to compete against similar requests for programs supporting such noble causes as erasing poverty, supporting family health, and expanding education. Note that the priority issue is not limited to legislatures and

budget issues. Police chiefs are inundated with a score of proposals seeking affirmative actions on the part of officers. Landlords and employers must tailor leasing and hiring duties to a slew of demands. In all cases, one reason mental health may frequently be towards the bottom of priority lists is that people in power endorse stigmatizing attitudes. Hence, changing attitudes may move mental health services up the priority list of public concerns.

Positive Attitudes and Affirmative Action

Note that the bottom half of Table 2 paints the other half of the attitude-behavior link; namely, positive attitudes and expectations about people with mental illness yield affirmative actions toward this population. An obvious point emerges when comparing the top to the bottom half of the Table. Researchers and advocates tend to know more about, and provide more focus on, the negative side of the attitude-behavior equation, understanding how stereotypes lead to discrimination. Clearly an important goal is to erase stereotypes, prejudice, and discrimination. There is, however, a fundamental rule in the psychology of attitude and behavior change that must be kept in mind here. **Any time a person seeks to stop a troublesome attitude or behavior, that attitude or behavior must be replaced by a positive perspective.** Hence, advocates who seek to erase the stigma need to identify positive attitudes and affirmative actions that can replace the previous, unjust approach.

Three examples come to mind as positive beliefs and expectations; recovery, goals, and empowerment. (1) The public needs to learn that people with mental illness can and do recover, and in significant numbers. Metaphors are frequently helpful here; comparing the person with mental illness to individuals in wheelchairs helps the public understand that even though disabilities might not totally disappear (some people use wheelchairs and some people live with psychosis for life), a full and satisfying life can be enjoyed. (2) Closely related to recovery is the attainment of life goals. People with every mental illness are capable of achieving the full range of education, work, independent living, relationship, recreation, and spiritual goals. This is an essential message because the public frequently believes that the person cannot achieve most of these goals because of mental illness. The public needs to learn that all opportunities available to Americans are also available to those Americans with mental illness.

(3) People with mental illness flourish when they have power over their lives and their treatment. This, too, reflects an American ideal. Individuals should have the right to pursue their dreams as long as those pursuits do not infringe on the rights or opportunities of others. The childlike stigma seems to especially challenge this idea; “individuals with mental illness are not capable of making decisions about their own life so some wiser more competent authority needs to be given the responsibility.” Wrong! Research shows that people with mental illness, like most individuals, want control of their lives and use this control effectively.

In Table 2, the behaviors that result from positive expectations and beliefs were labeled affirmative actions. A brief history about this term explains its inclusion in the

table. In the pursuit of civil rights, some advocates believed that equal opportunity would help people of color achieve the same breadth and depth of goals as the majority white culture. Equal opportunity meant erasing all disparities that had arisen because of prejudice and discrimination so that such important playing fields as business, employment, housing, and health care were level. Unfortunately, more than 100 years after the Civil War, African American and other ethnic minority groups were faced with continuing poverty, poor health, low level-jobs, crime-ridden neighborhoods, and family upheaval. Advocates realized that a level playing field was not enough to correct centuries of misunderstanding, prejudice, and discrimination. Affirmative actions that actively sought to change the status quo were needed.

I do not use affirmative action in a manner that is synonymous with the contentious social change strategy that has ended up in the Supreme Court. Rather, I see affirmative actions as a set of behaviors that purposefully and proactively attempt to increase opportunities. Some of these actions are embodied in federal legislation like the Americans with Disabilities Act that directs employers to provide reasonable accommodations (e.g., quiet work place, support of a job coach) so that a person with psychiatric disabilities is able to be fully employed. Similarly, the Fair Housing Act requires landlords to provide reasonable accommodations so the person can live independently (e.g., on-site support of a housing coach). Alternatively, affirmative actions include the efforts of legislators and other government officials who are seeking increased funding for programs that promote empowerment and recovery. Affirmative action may include the efforts of primary care physicians who do not dismiss physical complaints by a patient with mental illness as another example of hypochondria. Mental health professionals may promote affirmative action by replacing custodial services with programs that help people attain real-world life goals. In all these examples, the emphasis is on actions; efforts that can be made by people in key power positions that enhance the life opportunities of people with mental illness.

Empathy is the goal. As explained earlier in this handbook, negative emotional reaction (e.g., fear, anger, disgust) that corresponds with endorsing the stereotypes energizes prejudice and discrimination. Similarly, positive emotional reaction that corresponds with empowerment and recovery can also energize the counters to prejudice and discrimination. The primary emotional reaction of interest here is empathy. The goal of anti-stigma programs is to have participants develop a sense of what it means to walk in the shoes of a person with mental illness. Empathy fosters a sense of likeness; people with mental illness are just like me. Discrimination flourishes in a mindset that a certain group is somehow less than human or different than the norm. It is difficult to sustain this kind of “differentness,” and the discrimination it produces, when the public has empathy for a group.

Note that the goal here is empathy, not sympathy. Many anti-stigma programs tout the message that mental illness is a brain disorder and that the public should help people with mental illness because of their unfortunate condition. This kind of approach may diminish some of the negative stereotypes about mental illness; e.g.,

“that people with these disorders are somehow to blame for them.” However, the pity which this approach may create can lead to a different stigma; e.g., people with mental illness are sick and incapable of making adult-level decisions. Most certainly, sympathy does not challenge the differentness issue. The goal is: PARITY, NOT PITY!¹

How Reward and Punishment Augment This Model

The essence of the rational actor model is the belief that attitudes about a group causes behaviors toward that group. Change the attitudes and behaviors will follow. Psychologists have argued that other factors are important in augmenting this relationship; perhaps most important of these is rewards and punishers. According to operant psychology, rewards that follow an attitude-behavior link strengthen that link while punishers weaken it. Examples are provided in Table 3.

The relationship between rewards, punishers, and the attitude-behavior link is complex. Rewards and punishment can yield different goals for advocates depending on whether the focus of these consequences is stigmatizing attitudes and discriminatory behaviors OR positive expectations and affirmative actions. Consider the impact of rewards and punishers on the link between stigmatizing attitudes and discriminatory behaviors. A person who is rewarded for a stigmatizing belief paired with a discriminatory behavior will likely repeat that behavior. For example, a politician believes that mandated treatment should be at the center of most mental health treatment systems. Her position becomes strengthened when a group announces their support for the politician and policy, agrees to campaign for her, and supports her campaign fund. Conversely, theater owners are less likely to show “psycho-killer” films when customers stop purchasing tickets as punishment for that action.

Table 3. Examples of how rewards and punishers affect the attitude-behavior link. Note that only the examples in the bold boxes are consistent with the goals of most mental health advocates. The italicized positions are more consistent with the status quo that often blocks opportunities for people with mental illness.

| | Stigmatizing Attitude Yields Discriminatory Behavior | Positive Expectation Yields Affirmative Action |
|------------|---|---|
| Reward | <i>A group publicly supports a politician who maintains more mandated treatments are needed to control violent patients</i> | A real estate firm is awarded a public citation for its efforts to lease to and support people with mental illness |
| Punishment | A group boycotts movie theaters that show films that perpetuate stigma | <i>Employers decrease business with other firms that hire people with mental illness</i> |

¹ Many thanks to friends and colleague Peter Byrne for first educating me about this battle cry

One way to enhance the advocate's agenda is by rewarding people for their positive expectations and affirmative actions.

Rewards and punishers also influence the positive expectations and affirmative actions link. A real estate firm is more likely to continue its view that people with mental illness can be excellent tenants and actively lease to this group when they are publicly heralded for their affirmative actions by receiving a citation. Conversely, an employer may back away from positive expectations and hiring people with mental illness when colleagues stop sending him business because “he employs too many disabled people.”

What are the rewards and punishers that bring about these consequences? This issue is discussed more fully in Lesson 3 on project change strategies. Generally, however, rewards are events that are personally satisfying while punishers are hurtful things to avoid. Obviously, rewards and punishers vary by individual person; some people like chocolate while others prefer vanilla. Nevertheless, rewards and punishers are often similar within particular groups. Many government officials yearn for votes and the support of groups that can deliver these votes. Employers and landlords are typically business people who are rewarded by large markets and customers within these markets who purchase their goods and services. Health care providers want positive feedback to their insurance companies and other funders so revenue continues to flow. In each case, withholding these commodities can dissuade a person from a specific attitude and behavior link.

Sending the attitude underground. Generally speaking, rewards and punishers have a greater effect on *behaviors* than on *attitudes*. Hence, rewards and punishers may change obvious behaviors while producing no effect on corresponding attitudes. Consider the example of the employer who says she is a proponent of hiring people with mental illness (verbal behavior) but who still believes that individuals with psychiatric disability are basically incompetent (unchanged attitude). Researchers call the phenomenon of speaking positive words but not following up with action *social desirability*. Most citizens in America realize that obvious prejudice is strongly discouraged so they opt to endorse equal opportunity views of minority groups: to act in a socially desirable way. However, many people still harbor stereotypes and prejudice. Consider, for example, research on race. Many people from the White majority might say that people of color should have the same opportunities as Whites, but they still think Whites are superior to Blacks.

Is changing the behavior without the attitude a problem? On one hand, an advocate might say “who cares” whether employers are open-minded as long as they are hiring people with mental illness. And in terms of the goal of increased employment for people with psychiatric disability, changed behavior is clearly a

suitable outcome. As another example, who cares whether legislators believe in recovery and empowerment as long as they vote for legislation that significantly increases mental health services to promote these goals? Unfortunately, undercover stereotypes and prejudice can lead to what some researchers call *modern racism or prejudice*. No longer are people who believe in racist stereotypes yelling derogatory words at people of color. Instead, they are mouthing equal opportunity statements while opposing affirmative actions. “Sure, all people of color should have an equal chance at a quality college education. But that does not mean that they should have an advantage in the admissions process.”

How might this form of modern prejudice affect people with mental illness? Consider the employer who publicly states that hiring people with mental illness is a priority, but privately believes they are incompetent as a group. She is likely to find other excuses that prevent the actual hiring of people with psychiatric disabilities. She may limit job opportunities to those at the low end of the pay scale. She is likely to undermine reasonable accommodations, small changes that make the work place more conducive to people with psychiatric disabilities. Advocates need to keep in mind that changing the behavior may not be enough.

BEYOND THE RATIONAL ACTOR

The discussion on modern racism and prejudice is only one example where stigma is not explained solely by the clear connection between attitudes and behaviors. Many of our opinions about and reactions to people with mental illness are not conscious or deliberate. They seem to occur almost automatically and outside one’s awareness. Consider, for example, a woman who encounters a homeless man pushing a shopping cart down the street and crosses to the other side to avoid interacting with him. She is not consciously computing: “homeless means mentally ill means dangerous: cross to the other side.” Rather she ends up across the street without thinking about it. As another example, consider the legislator who must support some human service funding bills to the exclusion of others. He does not deliberately decide that mothers and children’s programs are more deserving than adults with mental illness. But he nevertheless votes more funding for the mother/child programs and leaves untouched the mental health budget session after session.

Research has identified several reasons that explain why the public may respond unconsciously in a prejudicial manner to a minority group. Briefly, unconscious prejudice may reflect the length of time in which stereotypes and prejudice are learned; typically young children show many of the stereotypes that are used against minority groups. A more complete discussion of these reasons is outside the scope of this manual. However, the implications of unconscious prejudice need to be considered when crafting advocacy efforts. Many people in power, who are the target of advocacy efforts, are not always aware of attitudes that lead to some form of discrimination against people with mental illness. Hence, “head on” approaches whose goals are to get them to stop thinking that way can be perceived as irrelevant,

especially in the face of the “Not me” effect. “Not me. I’m not prejudiced. Perhaps the other guy, but I am totally open-minded.” Note that the “Not me” effect supports a point made in the preface. Most people who discriminate or otherwise hold positions that fail to support empowerment and recovery do NOT do so deliberately or because of some conscious effort to deprive the life opportunities of people with mental illness. Their positions develop as the result of a lifetime

Not all discrimination represents rational conclusion based on conscious prejudice. Sometimes people act in a discriminatory manner without consciously being aware of their prejudice.

of exposure to stereotypes about mental illness. This knowledge is important because it may help advocates redirect their energy from rage at the bigot to a more strategic approach aimed at misguided or ignorant people. Lesson 3 on strategies specifically discusses ways to address unconscious prejudice.

SUMMARY

Many advocate goals are blocked by some form of stigma: (1) explicit attitudes that lead to discriminatory behavior or (2) unconscious prejudice which leads to more subtle forms of discrimination. Conversely, there are positive expectations and affirmative actions which, when in force, significantly advance the mental health agenda. Advocates need to be aware of these various forms of bias and opportunity when seeking change in key power groups.

LESSON 2: IDENTIFYING THE TARGET

It is because of the devotion or sacrifice of individuals that causes become of value.- Julian Huxley

As argued earlier in this handbook, stigma change and accomplishing advocacy goals are more effective when they are targeted; “Target” has a double meaning here. It is first defined in terms of specific social groups who are powerful vis-à-vis people with mental illness. Examples of these groups are listed in the first column of Table 4. Power here is based on functional relationships; the groups in Table 4 are frequently in positions of control and authority relative to the life decisions of people with mental illness. In particular, they can exercise behavioral options that curtail the life opportunities of individuals with mental illness. This is the second definition for targets and is highlighted in Table 4 as specific discriminatory behaviors.

Table 4 includes two other columns relevant to understanding how different power groups approach the stigma issue. *Corresponding attitudes*: from a rational actor perspective, what are the stereotypes held by a group that might explain specific discriminatory behaviors? For example, some employers may believe people with mental illness are dangerous and do not hire individuals with psychiatric disabilities to protect co-workers from possible harm. Alternatively, some employers may believe that people with mental illness are fundamentally unable to manage the demands of real work. Hence, they do not hire people with psychiatric disabilities so that work productivity is not diminished. Advocates need to understand the attitudes that may be driving discriminatory behaviors if they are going to craft programs that seek to enhance a work-related agenda by diminishing these false beliefs.

The second factor in Table 4 is *social context*. Various cultural, historical, legal, political, and economic forces influence the ways in which members of target groups think about individuals with mental illness. As outlined in Table 5, these various forces may be grouped into two types of social contextual factors that influence the attitude-behavior link. First, personal factors are generally static characteristics of the individual that influence enduring qualities of the person. Common examples of these variables include ethnicity and gender. Research generally shows that people of color and women are less likely to endorse the prejudice of mental illness or act on this prejudice in a discriminatory manner. People of color, in particular, are sensitive to issues of discrimination given their own experiences with prejudice throughout much of American history. Religion and life philosophy may also be related to prejudice and discrimination. As discussed earlier, research suggests those who endorse the Protestant work ethic (pull yourself up by your boot straps) are more likely to agree with the stereotypes of mental illness. Religions that view mental problems as the result of possession by evil spirits or sin are less likely to be sympathetic to persons

| TARGETS | DISCRIMINATORY BEHAVIOR | CORRESPONDING ATTITUDES | SOCIAL CONTEXT |
|--------------------------------|--|---------------------------------|--------------------------|
| LANDLORDS | -Fail to lease -No reasonable accommodation | | |
| EMPLOYERS | -Fail to hire -No reasonable accommodation | -Dangerousness -Incompetence | -Economy -Hiring pool |
| HEALTH CARE PROVIDERS | -Withhold some services -Unnecessarily coercive treatment | | |
| CRIMINAL JUSTICE PROFESSIONALS | -Unnecessarily coercive -Fail to use mental health services | | |
| PUBLIC POLICY MAKERS | -Insufficient resource allocation -Unfriendly interpretation of regulations | | |
| THE MEDIA | -Perpetuation and dissemination of stigmatizing images | | |

Table 4: Six groups whose attitudes about and behavior towards people with mental illness have significant impact on their life opportunities. The groups are described in terms of specific behaviors that may lead to discrimination, attitudes that correspond with these behaviors, and the social context in which these attitudes and behaviors occur. As an example, corresponding attitudes and social context are illustrated for employers. A more complete discussion of attitudes and context is provided later in this lesson.

with mental illness. Finally, familiarity through direct interpersonal experience with disability in general, and mental illness in particular, is likely to be inversely associated with stigma. In other words, people who are family to or friends with individuals with psychiatric disability are less likely to endorse the stigma of mental illness.

| Personal Factors | Current Events |
|--|-----------------------------------|
| Ethnicity and cultural background Gender Religion and life philosophy Familiarity with disability | Economics Statutes Politics |

Table 5. Two levels of social context: personal variables that represent the immediate family and culture in which someone was raised, and current social factors representing the influence of the changing times.

Second, current events are likely to influence targeted rational actors. As outlined in the Table, they include the state of the economy, politics, and laws. Since current events are more likely to influence rational actors based on their power group, we discuss them more fully in the remainder of the lesson.

POWER GROUP TO TARGET

There are many different power groups whose decisions can affect the lives of individuals with mental illness. However, research on six groups in particular has shown them to be important targets for advancing the mental health agenda: landlords, employers, health care providers and administrators, police and other representatives of the criminal justice system, public policy makers, and members of the media.

Landlords

Housing is an especially important goal of many people with serious mental illness. Like most adults, they want to live in safe and comfortable places. Also like most adults, they wish to select with whom they live: spouse, children, other family members, friends, or alone. Unfortunately, many people with psychiatric disabilities are unable to attain these goals. Two sets of landlord behaviors block housing goals. First, many landlords refuse to rent to people with mental illness. Some landlords may set different terms, conditions, or privileges for rental of a dwelling. For example, they may decide to increase the rent or damage deposit for units being leased to people with mental illness.

Landlords who believe some of the stereotypes of mental illness are less likely to rent to people with these kinds of problems.

Second, landlords may block independent housing goals by not permitting reasonable accommodations. Reasonable accommodations are legal mandates that require most landlords (and most employers for that matter) to provide relatively minor changes to housing so that a person can more easily live there given his or her disabilities. Typical images of reasonable accommodation include structural changes that allow a person using a wheel chair to easily navigate the building. However, reasonable accommodations also exist for people with psychiatric disabilities. In housing, accommodations may include permitting family members or service providers to co-sign a lease, allowing housing coaches access to the property to provide services including emergency interventions, and enhancing noise reduction rules to reduce ambient stress. The 1988 amendment to the Fair Housing Act prohibits rental discrimination and requires reasonable accommodations for people with

disabilities; nevertheless, research suggests that landlords continue to discriminate in these ways.

There is a related form of discrimination that may be evident at the community level known as NIMBY: not in my backyard. This translates as housing programs are okay in other parts of the city but not in my neighborhood. In these cases, it is not landlords, but people from the community who are blocking the housing options of people with mental illness.

Attitudes. Table 6 lists some of the attitudes that may cause landlords to limit people's housing options. Most prominent among these is dangerousness, incompetence, and contagion. Landlords who believe people with mental illness are dangerous do not want to risk violence in their building. They may be afraid that other renters will move out when they learn a unit has been rented to a person with mental illness. Landlords may also worry about incompetence; namely, that the renter with mental illness is incapable of keeping a clean and orderly household. Damage and subsequent repair costs may offset revenue enjoyed by the landlord. Finally, landlords may believe in contagion. Namely, they may think that they or their family may somehow be negatively affected by associating with renters with mental illness.

Table 6. The discriminatory behaviors, corresponding attitudes, and social contexts of landlords.

| TARGETS | DISCRIMINATORY BEHAVIOR | CORRESPONDING ATTITUDES | SOCIAL CONTEXT |
|-----------|--|--|--|
| LANDLORDS | <ul style="list-style-type: none"> -Fail to lease -No reasonable accommodation | <ul style="list-style-type: none"> -Dangerousness - incompetence -Contagion | <ul style="list-style-type: none"> -Economy -Neighborhood -Local ordinances -Number of units and proximity |

Social Context. Four contextual issues may influence the landlord's attitude-behavior link: the current state of the market, the neighborhood in which the building is located, municipal ordinances that govern realty, and the size of the property. Landlords are more likely to act on stigmatizing attitudes when enjoying a seller's market; namely, when several applicants, including people who are not apparently disabled, are seeking an individual rental unit. Conversely, landlords are more likely to rent to people with mental illness regardless of whatever negative attitudes they might hold about the group, when few people are lining up to sign the lease. Related to the economy is neighborhood. Landlords in some parts of large metropolitan areas are more likely to rent to people with mental illness than others. These areas are typically the more impoverished parts of town where neighbors are less likely to complain if a person with psychiatric disability moves in.

Local ordinances are relevant concerns to landlords. Although one might think these ordinances reinforce points of the Fair Housing Act, instead municipalities

frequently enact rules that may hamper rental agreements between landlords and people with mental illness. Most typical are building codes that specify the number of unrelated adults who may cohabit in a rental unit. Fire codes have also been used to keep people out of what has been framed as “unsafe housing for those with disabilities.” Although these rules are especially troublesome for programs seeking to set up formal living arrangements for groups of people with disabilities, landlords may also interpret them as unfriendly for leasing to individuals.

The size of the rental concern may also be relevant. Large rental firms that manage hundreds of units will respond differently from a two-flat landlord who is seeking to rent out the upstairs apartment. The rental firm will likely see leasing as a business issue and attend closely to government rules and regulations that restrict its activities. Landlords concerned about only a few units to which they live in proximity are more likely to be affected by their prejudices.

Employers

Real-world work (rather than employment in sheltered workshops) helps people with psychiatric disability meet several life goals. Most rehabilitation experts agree that, with supported employment services that include job coaches who provide regular on-site assistance, most people with serious mental illness can obtain and successfully work at a wide array of jobs available throughout the American economy. Working in real-world jobs meets adult goals related to a sense of vocation. Namely, most adults want to have a sense that they are busy doing something that is somehow important or meaningful. Moreover, real jobs help adults establish their social network. Most American adults make friends among the people they work with every day. Finally, real work helps people obtain a living wage and, in many cases, insurance and other benefits to protect their health and welfare.

Unfortunately, research suggests that up to 90% of people with mental illness, especially those with the most significant psychiatric disabilities, are not working. Although there are many causes for this shortfall, employers who endorse the stereotypes of mental illness are a significant barrier to work opportunities. As with housing, there is federal legislation that prohibits discrimination in the work place; in this case, the Americans with Disabilities Act specifically protects people with psychiatric disabilities at work. Nevertheless, as shown in Table 7, employers may opt not to hire people with mental illness or they may provide misinformation about the availability of existing positions. Alternatively, employers may block reasonable accommodations that would help people with mental illness stay on the job.

Attitudes. The general class of attitudes that lead to employment discrimination parallels those that cause landlords to discriminate. In particular, employers who believe that people with mental illness are dangerous do not want to risk violence for themselves, their employees, and their customers. In addition, some employers may believe that people with mental illness are incapable of working a regular job. They believe that employees may not have the skills necessary for the job or may not be capable of adjusting to work demands; e.g., a full work schedule or a

| TARGETS | DISCRIMINATORY BEHAVIOR | CORRESPONDING ATTITUDES | SOCIAL CONTEXT |
|-----------|---|--|--|
| EMPLOYERS | <ul style="list-style-type: none"> -Fail to hire -No reasonable accommodation | <ul style="list-style-type: none"> -Dangerousness -Incompetence -Unpredictability | <ul style="list-style-type: none"> -Economy -Hiring pool -Customer base -Business size |

Table 7. The discriminatory behaviors, corresponding attitudes, and social contexts of employers.

demanding supervisor. Discussion of issues related to reasonable accommodation might only reinforce views of incompetence. Some employers might assume that if people with disabilities were really capable of regular work, they would not need these kinds of accommodations. Both the dangerousness and the incompetence stereotypes are worsened by views of unpredictability. Employers may fear that they will not be able to discern when the person will be violent or unable to competently complete his or her job. So the employer might as well err on the conservative side and never hire the person.

Social Context. As outlined in Table 7, four social factors influence employer attitudes about and behaviors towards people with mental illness. Like landlords, some employers are more likely to discriminate against people with mental illness when the economy influences the hiring pool. In particular, some employers may overlook hiring people with mental illness when other applicants present themselves for the job. Employer perceptions about their customer base may also influence this link. That is, employers who believe customers will not want to interact with employees with mental illness may withhold job opportunities accordingly.

Finally, business size will affect the attitude-behavior link. Owners of large businesses or corporations are likely to delegate hiring to human resource directors who, in turn, are probably familiar with government regulations and attempt to adhere to them closely. Owners of relatively small businesses are more likely to work alongside an employee with mental illness; hence, personal biases may influence their hiring decisions.

Health Care Providers and Administrators

The American general health care system is a model for much of the rest of the world in the quality of care it provides patients largely regardless of their ability to pay. Unfortunately, research suggests that discrimination prevents many people with mental illness from fully enjoying this system. Some physicians and other health care professionals fail to provide the full range of services for people with mental illness. For example, research has shown that people with mental illness receive fewer insurance benefits than those without mental illness.

Attitudes and context. Two sets of attitudes, outlined in Table 8, may account for this kind of discriminatory behavior. First, most physicians are aware that health care resources are limited; as a result, they have to triage patients so those most in need or “most deserving” are referred to higher-order services first. The relevant

| TARGETS | DISCRIMINATORY BEHAVIOR | CORRESPONDING ATTITUDES | SOCIAL CONTEXT |
|-----------------------|-------------------------|---------------------------------|---------------------------------|
| HEALTH CARE PROVIDERS | -Withhold some services | -Incompetence (worth) -Blame | -Statutes & rules -Clientele |

Table 8. The Discriminatory behaviors, corresponding attitudes, and social contexts of health care providers.

stereotype about mental illness here is that people with these disorders are fundamentally incompetent and thus a drain on society's resources. In a triage scheme, they may be considered as having less worth and hence be given low priority among people who are deserving of services. This judgment is further exacerbated by blame; i.e., persons with mental illness are even less deserving of limited health resources because they are responsible for their psychiatric problems. If they had made other life choices or had a stronger moral character, then they would not be a drag on the American health system.

Two sets of contextual variables will affect the health care provider's link between attitudes and behaviors. First, American health care settings are dominated by a variety of statutes and rules related to denying treatment. These are embodied in federal legislation, in entitlement programs provided by federal and state governments (e.g., Medicaid and Medicare), in contractual agreements between private insurers and providers, and in the medical staff organizations governing local health care systems. For purposes of this discussion, these rules may be distinguished into those relevant to: treating people in emergency situations, providing medically necessary but not emergent services, and offering elective and preventive treatments. Simply put, providers are not allowed to withhold services in emergent situations under any circumstances. Medical necessity and elective procedures are largely dictated by the benefits provided in the person's health coverage (private versus government entitlement). Most care providers and health care systems are aware of these rules and try to comply with them. However, as noted in the earlier discussion of the ADA and Fair Housing Act, there is enough "wiggle room" in any rule for a practitioner to side step some component should he or she choose to do so.

A second context relevant to the link between health care provider attitudes and behaviors is clientele. Practitioners working in boutique settings with relatively wealthy clients may set up clinic rules that are less hospitable to people with mental illness. Conversely, providers working in government clinics for a largely indigent clientele are more likely to be open to serving individuals with mental illness.

Mental health service providers. The mental health system has changed dramatically during the past two decades from a set of programs that were largely custodial, trying to help people with serious mental illness comfortably live out their lives in institutions, to rehabilitation-oriented programs, helping people attain "normal" life goals – work, residence, and relationships – in their community. Ironically, many existing mental health providers are often a major barrier to

accomplishing the new vision of recovery. Some providers are unwilling to endorse the new approaches to mental health services that are based on community support and skill development. Others dominate their practice with concerns about mandated treatments and managing the symptoms of patients who lack insight into their plight.

Attitudes and social context. Two sets of attitudes may account for the lag in mental health vision shown by some providers. First, many professionals do not accept the principle of

Mental health providers who are dominated by concerns about dangerousness and incompetence are likely to block positive expectations that reflect a recovery-oriented approach to services.

recovery because of psychiatry's history with explaining disease and inevitable decompensation. Emil Kraepelin, a German neurologist, first equated serious mental illnesses with a progressive downhill course. Those diagnosed with these disorders, by definition, were not expected to recover but rather to languish in hospitals as their illness worsened over time. Long-term follow-up research, however, has largely discredited this view showing that most people with serious mental illnesses such as schizophrenia recover. The clash of Kraepelinian views and long-term follow-up research has led to what researchers call the clinician's illusion. The practitioner's treats some people with chronic disorders who continually return to the clinic when they are sick. The practitioner never sees them when they are well. Hence, the doctor assumes that people with these kinds of chronic disorders are always sick. As a result, their treatment programs focus on custodial services and ignore more rehabilitation-oriented approaches.

Table 9. The discriminatory behaviors, corresponding attitudes, and social contexts of mental health care providers.

| TARGETS | DISCRIMINATORY BEHAVIOR | CORRESPONDING ATTITUDES | SOCIAL CONTEXT |
|-----------------------|---|--|--|
| HEALTH CARE PROVIDERS | <ul style="list-style-type: none"> –Unnecessarily coercive treatment –Don't promote rehab | <ul style="list-style-type: none"> –No recovery –Childlike | <ul style="list-style-type: none"> –State mental health authority |

Viewing patients as childlike is a second stigmatizing attitude that may undermine state-of-the-art rehabilitative services. Namely, some providers believe that individuals with mental illness are unable to understand the extent of their disabilities and therefore need an authority who can make decisions for them. It naturally follows that the mental health care provider should be this authority; he or

she must mandate treatments and even commit people to institutions when the “patient” does not comply with the treatment plan and is dangerous to self or others.

Statutes and rules also affect the link between attitudes and behaviors in mental health providers. In this case, however, these kinds of rules are often requirements of state or county mental health authorities about the format of services that a clinic must provide in return for government funding. Two agenda items currently dominate the state mental health agenda and, depending on local rules, have diametrically opposite effects on mental health practice. At one pole is the recovery-based mental health system. In 2003, President Bush’s New Freedom Commission on Mental Health anchored its vision for mental health with a recovery-based approach. Namely, services need to be fundamentally empowering and organized to help people with mental illness achieve life goals in their community. At the other extreme is mandated care. This is a collection of interventions including inpatient commitment, outpatient commitment, and representative payee services that are meant to control people who are incapable of recognizing appropriate life choices because of their disability. These two concerns are not mutually exclusive; many mental health authorities have attempted to balance both issues in their strategic plans. What is of concern here is how the individual mental health provider understands this dialogue in his or her locale. Those who perceive the state or county as especially concerned about mandated care are more likely to perpetuate stigmatizing attitudes that lead to authoritarian treatments.

Criminal Justice Professionals

With the inadequate provision of mental health services in the community, many people with mental illness have found themselves more involved in the criminal justice system. The number of people with mental illness in jails has risen by more than 150% in the past 20 years. Somewhere between 5% and 10% of people considered crime suspects by the police have a history of mental illness. A person’s interaction with the police is not limited to being a crime suspect; he or she also may be in need of police assistance as a victim, witness, or in some other non-crime-related manner. For a person with mental illness, police officers are often the first point of contact with the criminal justice system. The officer’s determination impacts whether persons with mental illness receive adequate psychiatric care or are further processed into the criminal justice system.

Unfortunately, most officers do not receive any specific training for interacting with citizens with mental illness other than a couple of hours in the academy. Hence, officers are likely to be dominated by the same stigmatizing attitudes as the rest of the population. They may behave in two ways that are discriminatory or in some other way harmful to people with mental illness (see Table 10). First, they may react to a person with mental illness in a defensive manner that results in unnecessary coercion and harm. Several news stories in the past few years have documented cases where police responding to a situation involving a person with mental illness overreacted leading to significant injury and, in some cases, death. Second, they may ignore

people's mental health needs and fail to access special services that would be immensely useful to the officer and the person with mental illness. For example, there are Assertive Community Treatment teams and mental health courts specially trained to deal with offenders with mental illness. There are consumer-run drop in centers where the homeless person with mental illness can get off the street. Some officers, in response to their prejudice, may opt to ignore these services, instead forcing the suspect with mental illness down the traditional criminal justice track.²

Attitudes and social context. The major stereotype endorsed by some police officers that can lead to the discriminatory behaviors outlined in Table 10 is dangerousness. Believing that a person who is labeled mentally ill is likely to be violent is naturally going to make officers more defensive and may possibly lead to overreactions. The neighborhood which officers patrol is an important contextual variable that will influence their attitude-behavior link. High poverty, low employment, and high crime will affect attitudes about and behaviors towards people with mental illness, although the specific nature of the interaction may be paradoxical. On one hand, high crime and poverty may force officers to be so much on guard that any interaction that might possibly lead to violence (such as an encounter with a person labeled mentally ill) is more likely to lead to violence. Hence, officers may treat people with mental illness more harshly in impoverished, high-crime areas. Alternatively, the degree of police involvement with people with mental illness may pale compared to the level of street crime found on these kinds of beats. Officers may be less likely to react strongly to relatively milder incidents in which people with mental illness are involved.

Table 10. The discriminatory behaviors, corresponding attitudes, and social contexts of criminal justice professionals.

| TARGETS | DISCRIMINATORY BEHAVIOR | CORRESPONDING ATTITUDES | SOCIAL CONTEXT |
|--------------------------------|--|-------------------------|----------------|
| CRIMINAL JUSTICE PROFESSIONALS | -Unnecessarily coercive -Fail to use mental health services | -Dangerousness | -Neighborhood |

² This is a place in the manual where the earlier caution about “stigmatizing the stigmatizer” needs to be repeated. In pointing out how police officers overreact to individuals with mental illness and harm them in the process, I am not saying they are bigots whose use of force equivalent to Selma, Alabama sheriffs beating on African Americans who were protesting racism. I do not believe most officers are somehow to blame for stigmatizing attitudes or discriminatory behavior and therefore should be punished for this kind of response. Rather, officers, like other people who stigmatize, are acting out a normally occurring psychological process. This process needs to be understood to most effectively change people's behavior.

Public Policy Makers

Public resources support much of the mental health system, especially for people with serious disorders. Hence, legislators and other policy makers are in positions to help advocates achieve their mental health agenda. Alternatively, policy makers are able to severely curtail these agendas. Two sets of discriminatory behaviors seem relevant to legislators and policy makers (see Table 11). First, members of this group seem to be unwilling to allocate sufficient resources to mental health services. As evidence, consider that 1990's levels of funding having dropped more than 8% from the preceding decade even though service needs did not change. In a related fashion, many legislators have been unwilling to pass an insurance parity bill that equalizes insurance benefits for mental and physical health. Second, policy makers and legislators seem unwilling to interpret existing legislation in a manner that is friendly to mental health. Note that it took more than five years for the Equal Employment Opportunity Commission to issue an interpretation of the Americans with Disabilities Act (ADA) that was specifically sensitive to the needs of people with psychiatric disabilities.

Table 11. The discriminatory behaviors, corresponding attitudes, and social contexts of policy makers.

| TARGETS | DISCRIMINATORY BEHAVIOR | CORRESPONDING ATTITUDES | SOCIAL CONTEXT |
|---------------|--|--|---|
| POLICY MAKERS | <ul style="list-style-type: none"> -Insufficient resource allocation -Unfriendly interpretation of regulations | <ul style="list-style-type: none"> -Blame: onset and offset | <ul style="list-style-type: none"> -Political Party -Election status -Constituency |

Attitudes and social context. The attitude most likely to lead to the discriminating behaviors in Table 11 is blame. Researchers have distinguished two types of blame that are relevant here: onset and offset. Onset blame represents the view that people originally get mental illness because of something they did for which they are personally responsible. The most common cause here is weak constitution or poor moral character; “if the person just showed a little more personal strength, he or she would not have become overwhelmed by their depression.” Offset blame means that once a person becomes mentally ill, he or she is responsible for doing whatever is needed to recover. Hence, people who do not get better are somehow to blame for their continued illness. Offset responsibility interacts with ideas about whether treatments are effective. Legislators who believe there are no good services for the symptoms and disabilities of mental illness will view recovery as an impossibility. The combination of views about onset responsibility, offset blame, and treatment ineffectiveness may lead public policy makers to block the expansion of community-based resources for mental health.

Public policy makers are fundamentally political creatures so that a variety of social contexts will influence the attitude-behavior link. The nature of current

legislative action makes political party affiliation hugely relevant. Depending on the state or community, political affiliation may influence action on a particular policy as much as 75% of the time or more. Put another way, public policy makers are likely to adhere to the party line regardless of their personal opinions about an issue. Hence, the attitude-behavior link of the individual policy maker often seems irrelevant. Advocates should not lose heart, however. Clearly there are leaders within a party who set the course for the group as a whole; these leaders may be especially fruitful targets for advocate efforts. Party leaders are somewhat limited by the fundamental assumptions of their party; relatively conservative groups are likely to be concerned about how social programs will cause government costs (and taxes) to increase while more liberal coalitions will be concerned about meeting the social needs of a broad range of groups.

Although many of the decisions of policy maker(s) are dictated by party affiliation, perhaps as much as a quarter of their decisions are not. This is especially apparent during periods of pending elections when the local constituency is likely to influence policy maker priorities. Constituencies that reflect concerns about mental health are likely to have particularly marked impact on legislators and other policy makers. One kind of policy maker who may especially be an ally of mental health advocates are people who have experienced mental illness themselves or who have a family member with mental illness. Legislators who are out of the closet on these issues should be hugely supported by advocates.

The Media

Recent, important research compared the prevalence of various stigmatizing attitudes in surveys conducted in the 1950's and 1990's. Results were sobering and suggested that twice as many people in 1990 as in 1950 were likely to endorse the violence stereotype about people with mental illness. In trying to explain this difference, the research team theorized that the rise of the entertainment Media, especially television, may be responsible for this increase. This is consistent with a separate set of research that has examined how various forms of the media represent people with mental illness; 75% of the time, people with mental illness are represented as dangerous. This occurs across media domains. It is evident in the entertainment industry (films, television comedies and drama, the fiction press, and talk radio) where the image of the "psycho killer" dominates. Of equal or greater concern, news media also seem to be dominated by images of the violent maniac. Newspapers and news shows on television and radio, which purport to be the bastion of objective thought, abound with stories about violent crime that results from mental illness.

Attitudes and social context. A first principle of media work is "If it bleeds, it leads." Tragedy, harm, and injury make for the most exciting fiction and the most interesting news. This principle dovetails with the myth of dangerousness in people with mental illness. People who are acutely ill, psychotic, and violent make the most interesting stories. People in recovery – individuals living with their mental illness, working, and being useful members of their community – do not make for engaging

| TARGETS | DISCRIMINATORY BEHAVIOR | CORRESPONDING ATTITUDES | SOCIAL CONTEXT |
|-----------|--|---|-----------------|
| THE MEDIA | –Perpetuation and dissemination of stigmatizing images | –“If it bleeds, it leads” –Dangerousness | –Tabloid status |

Table 12. The discriminatory behaviors, corresponding attitudes, and social contexts of the media.

news. The bleeds/leads motto interacts with the tabloid status of the medium. Those newspapers and shows that are most concerned with the sensational nature of the story, as opposed to the facts, are most likely to perpetuate the stereotypes about mental illness. Note that while tabloid newspapers and other media are most likely to front page stereotypes about mental illness, even relatively distinguished news outlets such as the New York Times and National Public Radio have been seduced by the “psycho killer” story and have reinforced the public’s notions about dangerousness.

TWO OTHER IMPORTANT TARGET GROUPS

Lesson 2 reviewed groups that should be targeted by advocates to advance the mental health agenda. Though not necessarily targets in this light, two other groups are influenced by stigma and need to be considered in the work of advocates: people with mental illness and their families. Individuals in either group may agree with the stigma of mental illness and apply it against themselves in ways that will yield discrimination of a different type. Table 13 summarizes this issue.

Table 13. Examples of stigmatizing attitudes and discriminatory behaviors experienced by people with mental illness and their families.

| | People with Mental Illness | Families of People with Mental Illness |
|-----------|--|---|
| Attitudes | Low self-esteem: <i>I am weak and to blame for my mental illness.</i> Low self-efficacy: <i>I am incompetent and unable to accomplish simple goals related to work and housing.</i> | Parents: onset blame, incompetence Siblings and spouses: offset blame Children: contagion |
| Behaviors | Why try: <i>Why try to get a competitive job, live in my own house, or start a serious relationship? I am mentally ill and will fail.</i> | Shame and avoidance |

People with Mental Illness

Some people with mental illness believe the stereotypes and turn the attitudes against themselves. This kind of self-stigma leads to two kinds of attitudes. The first results when the person internalizes the blame stereotype and results in lower self-esteem; “I must be weak because I am mentally ill!” The second relates to lowered self-efficacy, a diminished belief in one’s competency and ability to accomplish one’s goals. Lower self-esteem and diminished self-efficacy lead to a “Why try effect” marked by fatalism and low effort. “Why try to get a real job. I’m mentally ill and won’t be able to handle it anyway.”

A famous psychologist named Gordon Allport argued that self-stigma naturally occurred as the result of belonging to a stigmatized group. He believed, for example, that African Americans were likely to have lower self-esteem than European Americans because they are the butt of racial prejudice. Careful research, however, has found that not to be true. Instead, a collection of people from any stigmatized group might show one of three reactions to stigma: self-stigma, righteous indignation, or indifference. Hence, people with mental illness do NOT necessarily self-stigmatize. Some might show righteous anger, rebelling against the prejudice and discrimination perpetuated by the public. Others are indifferent to the issue altogether, believing stigma is either not important or personally irrelevant to them.

Two factors affect whether an individual is likely to self-stigmatize, be righteously angry, or be indifferent. First is perceived legitimacy: whether the person believes the stereotypes about mental illness are in some ways valid. People with mental illness who recognize the illegitimacy of common stereotypes are more likely to fall at the righteous indignation end of the continuum. Second is group identification; whether people recognize they are part of a stigmatized group and whether that self-identification yields shame or pride. The consumer movement that has led to mutual support and advocacy yields the kind of self-identification and pride that counters self-stigma.

Some people with mental illness and their families internalize the stigma of mental illness and believe they are unable to accomplish goals that are consistent with recovery.

Family Members of People with Mental Illness

Some family members of people with mental illness also self-stigmatize.³ The nature of the stigma depends on the relationship with the person with mental illness. Parents of a person with mental illness frequently experience blame and shame. Their incompetence as mothers or fathers caused their children to become mentally ill. Siblings and spouses often internalize offset blame stereotypes. They are responsible for their sibling or mate with mental illness and any relapses represent their failings. Children of people with mental illness may endorse contagion; that being brought up by a person with mental illness somehow makes them mentally ill and likely to fail in

life goals. Advocates need to realize that family members who are vital partners in promoting a mental health agenda can trip themselves up by internalizing these kinds of attitudes. Like people with mental illness, many family members are also able to fight the self-stigma by joining such advocacy and support groups as the National Alliance for the Mentally Ill.

SUMMARY

The attitude-behavior link that describes the rational actor model of mental illness prejudice is more powerful when it is fine tuned for individual power groups. Six groups were of special concern in this lesson because they repeatedly emerge as potential obstacles to progressive mental health agendas: landlords, employers, health care providers, criminal justice professionals, public policy makers, and the media. Lesson 2 provided specific examples of the attitudes which each group might endorse, the kinds of discriminatory behaviors that might emerge from the attitudes, and the social contexts which moderate this attitude-behavior link. Please note: the discussion of specific attitude-behavior links for each target group was not meant to be exhaustive. Clearly, people in any of these social roles are capable of manifesting the full range of stereotypes that hamper the life opportunities of people with mental illness. Police officers, for example, are not limited to dangerousness stereotypes.

Nor do I mean to suggest that the attitude-behavior link in each group is inevitable. Not every police officer is going to be concerned about dangerousness when he or she encounters a person with mental illness while on duty. Instead, my goal was to alert the reader that target groups, by virtue of being human, are likely to approach the mental health agenda biased by the demand of their role (of being a landlord, healthcare provider, or public policy maker, for example). I wanted to provide what are commonly discussed stereotypes that advocates might encounter when working with individuals from any of these groups. However, advocates must determine whether one stereotype or another holds for the specific group of people with whom they work. Failure to be sensitive to this kind of individual difference and uniqueness makes us guilty of stereotypes too; of treating people in a biased manner merely because they are in a specific group.

³ To reiterate a point made in the preface; labeling one group as family members may suggest that people with mental illness are not capable of being themselves. This manual does not mean to imply this and only uses the word “family” and “family stigma” as a handy way to refer to the prejudice experienced by people because of a relative with mental illness.

LESSON 3: SELECTING CHANGE STRATEGIES

Democracy is that form of society, no matter what its political classification, in which every man has a chance and knows he has it.- James Russell Lowell

The most effective anti-stigma programs are those tailored to the specific perceptions, concerns, behaviors, and contexts of targeted power groups. Lesson 3 offers a range of strategies to change the perceptions and actions of targeted groups. The most effective intervention plans, however, begin with a careful assessment of prejudice and discrimination as they appear in different targeted groups. Hence, this lesson begins with some strategies for obtaining information to better understand the target group.

ASSESS THE TARGET GROUP

Lesson 2 summarized frequently encountered attitudes that might yield discriminatory behaviors in targeted power groups. The Lesson ended with a caution which noted that although those were the most common attitude-behavior links, others are possible. Hence, Lesson 2 was meant to whet the reader's appetite for possible reasons why specific groups erect barriers to a progressive mental health agenda. Lesson 3 provides some direction so that advocates might obtain additional information directly from the targeted group which, along with Lesson 2, might help advocates to better understand that group's prejudice about people with mental illness. This understanding can then be used to craft the most effective advocacy campaign.

The best way to learn where a group stands on a specific mental health agenda is to go directly to representatives of that group. An effective and efficient strategy for obtaining this information is through a focus group. A focus group is an hour-long meeting between a skilled interviewer and eight to ten members of the target group. Focus group membership is usually restricted to individuals from the same power group. Hence, only police officers should be included in a frank discussion of why officers respond to people with mental illness in an occasionally discriminatory manner. Physicians are more likely to be candid about their reactions to patients with mental illness when in a group with other physicians who have shared similar experiences.

The goal is to get group members to freely speak about what peers think about people with mental illness and how this might lead these powerful individuals to block life opportunities. People without experience conducting focus groups should get David Morgan and Richard Krueger's "The Focus Group Kit" (published in 1998 by Sage Publications: Thousand Oaks, California). Perhaps the best advice for leaders conducting focus groups is "avoid being judgmental!" The group leader wants landlords, employers, police officers, or whoever comprises the group to speak frankly

about their perceptions of why certain goals on the mental health agenda are blocked by members of the power group. Group participants will not do that if the leader obviously disapproves of what group members are saying. If available, one solution would be to have a member of the targeted power group, who is savvy about the mental health advocacy agenda, lead the focused discussion.

The group leader needs to be aware of a second factor, discussed earlier in the handbook that may also affect the quality of responses: social desirability. Current American culture strongly disapproves of statements that sound prejudicial. Hence, focus group participants are not readily going to admit to any beliefs or behaviors that represent prejudice and discrimination. One way to avoid the social desirability effect is to have group participants speak in the third person; not about their own prejudice and discrimination towards people with mental illness but about behaviors they have seen or heard their peers discuss. Once again, any facilitation skills that avoid a tone of blame and disapproval will yield more forthright information about how the group may perceive people with mental illness.

The best way to identify attitudes that a group might endorse against people with mental illness is to ask in a focus group.

Develop an Interview Guide

Advocates sponsoring the focus group need to outline an interview guide that the group leader will use to direct the meeting. The interviewer guide includes an overall rationale for the meeting and a specific list of questions.

State the rationale. Focus group participants need to have a sense of the goals of the discussion. This should be handled in a forthright yet tactful manner. Examples of rationales for each of the targeted power groups are provided in Table 14. After sharing the rationale, the group leader needs to discuss a couple of ground rules. First, participants need to be informed that all information shared during the focus group will be confidential. Nothing that is said by group members will ever be specifically attributed to them. Second, although a healthy exchange of ideas advances knowledge, participants are encouraged to respect one another's comments. Hence, the group leader will be responsible for making sure that no specific exchange among group members becomes hostile.

Table 14: Rationales that might be used for focus groups.

| Target Group | Focus Group Rationale |
|--------------------------------|---|
| Landlords | <i>An important goal for many people with serious mental illness is to obtain safe and comfortable housing. Unfortunately, sometimes the attitudes and behaviors of some landlords can undermine this goal. We wanted your help in identifying what other landlords you know might be doing that blocks renting to people with mental illness.</i> |
| Employers | <i>Obtaining and keeping a regular job is as important to most people with serious mental illness as to most American adults. Unfortunately, sometimes employer opinions keep them from hiring people with mental illness or providing reasonable accommodations once they are on staff. We seek to understand what some of these opinions might be that are a barrier to work.</i> |
| Health Care Providers | <i>Some research suggests that the full range of physical health services are NOT provided to people with serious mental illness. For example, research shows that people with mental illness are less likely to benefit from the health system compared to people who are not labeled in this way. The purpose of this focus group is to identify physician attitudes and behaviors that might lead to this kind of disparity.</i> |
| Criminal Justice Professionals | <i>Many people with mental illness become involved in the criminal justice system as a suspect, victim, or witness. Unfortunately, police attitudes about mental illness may often undermine the quality of this interaction, sometimes leading to unnecessary aggression on the part of the officer. We wish to understand what some of these attitudes may be.</i> |
| Public Policy Makers | <i>State-supported resources for people with mental illness have actually decreased in the past decade. In part, this occurs because legislators do not consider mental health needs high in priority. We would like to understand some of the attitudes and beliefs held by legislators that push mental health down the priority list.</i> |
| The Media | <i>Research shows that three out of four times, the media represents people with mental illness as violent and dangerous despite other evidence that diminishes the connection between ideas about mental illness and violence. In this focus group, we seek to understand the attitudes of reporters and editors that might explain this disparity.</i> |

Identify the Barriers. After the rationale has been set, the real work of the focus group begins. The leader walks the group through a series of open-ended questions seeking to identify barriers to life goals of people with mental illness. A good rule of focus groups is to start with general questions and transition into specific ones. Consider the following questions for employers that could be adapted for focus groups with any of the targets.

- Let's begin generally by going around the room and discussing your experiences in hiring people with mental illness.
- Can you think of one story from your business, or that of another businessperson

you know, that illustrates the issue of hiring a person with mental illness?

- Overall, what are the advantages and disadvantages of hiring people with mental illness?
 - Let's talk more about the problems involved in hiring people with mental illness. What are some of these?
 - Sometimes employers do not want to hire people with mental illness because of their opinions about them. What are some of the opinions you have heard about them?
 - Sometimes outright biases prevent some employers from hiring people with mental illness. What might some of these biases be?
 - The U.S government says employers must provide reasonable accommodations⁴ to people with mental illness if they hire them. What do you understand reasonable accommodations to be?
 - What is your opinion about providing people reasonable accommodations?
 - Some employers have bad opinions about reasonable accommodations. What are some of these?
 - What are some biases employers have against reasonable accommodations? Is there anything about hiring people with mental illness that we did not discuss that you would like to add?
- A good question to end all focus groups, applied here to employers as an example, is:
- Our goal is to get more employers to hire and provide reasonable accommodations to people with mental illness. What strategies, in our advocacy with employers, would bring about this goal?

Incentive

An important question is, Why would members of a target group participate in a focus group? By virtue of being in a key power role they are likely to be busy. What incentives might advocates use to obtain good participation in the focus group? Focus group experts have suggested several strategies that may help attract participants.

Generally, paying people to participate is not a good incentive. Given the kinds of salaries that members from power groups earn, a relatively significant amount of money is needed to offer a meaningful incentive. Most advocacy groups cannot afford this. Instead, appeals to altruism may be a better way of recruiting focus group participants. Many people, especially those in power positions, see themselves as good citizens and want to help their community. Explaining the goal of the focus group is to improve opportunities for people with mental illness may encourage some people to volunteer.

Members of key power groups often join civic-minded organizations whose mission is to help their community. These groups include Rotary International, Lions Club, Kiwanis, and the Masons. These kinds of organizations can be especially

⁴ According to the Americans with Disabilities Acts, employers must "accommodate" or otherwise change a job so that persons with disabilities can complete all essential functions; the goal is to remove barriers that would prevent persons from doing the job because of their disabilities.

fruitful for recruiting employers or landlords for focus groups. Frequently, one of the advocates putting together the focus group may be an organization member and has inside access.

Members of other power groups also may be approached through existing organizations. Police officers are very concerned about community policing so that the local district commander is likely to be agreeable to a focus group. Physicians at the local hospital are governed by a medical staff organization that is likely to be responsive to patient concerns. Legislators are especially concerned about their constituency and likely to be willing to meet for this kind of cause. Another important issue related to incentive is convenience. Members of power groups are not likely to participate in focus group meetings that are at an inconvenient time or place. Hence, advocates putting together a focus group may want to brainstorm times and places that are least likely to be troublesome for participants. Among the most convenient of opportunities are already scheduled meetings which members of the power group regularly assemble. Hence, a focus group at a weekly meeting of a civic club may be especially convenient to participants.

Focus Group of People with Mental Illness

Obtaining focus group information from members of the power group provides one half of the picture. A good follow-up activity is to conduct a similar focus group that includes people with mental illness and, if relevant, family members and/or friends. The rationale is similar; for example, in terms of employment, the leader might say,

As you know, many people with mental illness want to get a regular job. One reason why they may not is the stigma of mental illness. Some employers believe the stereotypes about mental illness and discriminate against people accordingly. In this group, we want to understand the nature of some of these discriminatory ideas so we can help employers change them.

Focus group leaders then ask participants to identify some of their experiences with prejudice and discrimination during interviews and on the job. The focus group leader should also review findings from the employer group with the consumers and obtain their feedback. The goal here is not to join with angry consumers and blame employers for low employment. Rather, the leader should engage consumers in a scientific process by considering the information provided by employers, identifying those stereotypes and discriminatory behaviors that are particularly prominent, and adding any issues that employers may have left out.

Product of Focus Groups

The summary report of the focus group needs to outline two products. (1) What are the discriminatory behaviors acted on by this group of people in power?

How do they compare to the discriminatory behaviors listed in the target group in Table 4 of Lesson 2? (2) What attitudes accompany these behaviors? Once again, focus group leaders may wish to compare their findings to those listed in the various Tables of Lesson 2. Answers to these two sets of questions provide the content for the anti-stigma program which advocates will develop to challenge the discrimination in their community.

CHALLENGING THE RATIONAL ACTOR

Research has shown that advocates may draw from four sets of strategies to challenge the attitude-behavior link that causes discrimination: education, contact, protest, and consequences. Table 15 summarizes the basic rationale of each. The subsequent pages provide a more complete description of each approach and a summary of the advantages and disadvantages of each.⁵

Before this handbook more fully explains each of these strategies, some issues about incentive and convenience are discussed. Advocates need to consider what they can do to get busy members of key power groups to participate in anti-stigma programs. Many of the recommendations reviewed for focus group participation apply here. The anti-stigma programs need to be presented at times and places that are convenient to participants; e.g., regularly scheduled meetings of the group. Advocates need to find an ally who will convince the group to participate. Frequently, advocates are members of many of the civic groups that would make good targets for these programs. Other times, they might want to use their friends or acquaintances to present the idea of an anti-stigma program to the group.

Table 15. A basic definition of the four general strategies for challenging the attitude-behavior link.

| Anti-Stigma Strategy | Definition |
|----------------------|---|
| Education | Contrast the myths of mental illness with the facts |
| Contact | Facilitate interactions between people with mental illness and members of the power group |
| Protest | Frame the moral injustice of continued prejudice and discrimination; then instruct members of the power group to suppress the attitude. |
| Consequences | Reward people for positive expectations and affirmative actions. Withhold rewards for stigmatizing attitudes and discriminatory behavior. |

⁵ These strategies are more fully discussed in *Don't Call Me Nuts! Coping with the Stigma of Mental Illness* (by P.W. Corrigan & R.K. Lundin [2001], 456 pages; Tinley Park IL: Recovery Press).

Table 16: A dozen common myths about mental illness and facts that challenge these myths.

| Myth | Fact |
|---|--|
| Once crazy, always crazy. People don't get over it. | Long-term follow-up research suggests that many, many persons with the most severe types of schizophrenia and other serious mental illnesses are able to live productive lives. |
| All persons with mental illness are similar. | Persons with mental illness are as diverse a group of people as any other. Saying all persons with mental illness are alike is similar to saying all Latinos are the same. |
| Severe mental illnesses are rare, just like leprosy. | Actually serious mental illnesses like schizophrenia, manic-depression, and major depression may account for up to 8% to 10% of the population. That means 640,000 persons in a metropolitan area the size of Chicago, enough people to populate Omaha and Des Moines. |
| "The mentally ill" are dangerous, one step away from a maniacal killing spree. | Very, very few people with mental illness ever murder someone. In fact, the average person with mental illness is no more likely to be violent than the rest of the population. |
| "The mentally ill" can never survive outside the hospital. | The vast majority of persons with mental illness lives personally successful lives in their community. |
| "The mentally ill" will never benefit from psychotherapy. | Carefully controlled research has shown that support and rehabilitation have significant impact on the lives of persons with mental illness. |
| "The mentally ill" are unable to do anything but the lowest-level jobs. | Persons with mental illness perform at all levels of work, just like the rest of the population. |
| "The mentally ill" are like little children, unable to make difficult decisions and needing an authority figure to direct their life. | Persons with mental illness thrive on personal power over their lives and are able to make competent decisions most of the time. |
| "The mentally ill" choose their symptoms because they have a weak moral constitution. | Most mental illness results from biological causes. People do not choose to have a mental illness. |
| Other people will become infected by interacting with "the mentally ill." | Mental illness is in no way contagious, either biologically or morally. |
| "The mentally ill" are unpredictable and can snap with a moment's notice. | Much of human behavior is unpredictable. People with mental illness, for the most part, are as predictable as other adults. |
| Bad parents and bad upbringing cause severe mental illness. | Schizophrenia and the other severe mental illnesses are biological diseases. They are a product of the interaction between |

Education

Although a variety of education programs have been developed to challenge the stigma of mental illness, perhaps the most effective is a review of the myths of mental illness contrasted with facts that counter these myths. This is done in a lecture format, often with audiovisual aides, where the myths and facts summarized in Table 16 are presented. Advocates may want to partner with professionals who can provide documentation to support the facts that counter the myths. Lectures are much more successful when participants are drawn into an active discussion of the material.

Advantages and disadvantages. Generally speaking, education is a popular way to challenge the stigma of mental illness. Advocacy groups can easily put together lectures and other kinds of informational presentations that contrast the myths and facts of mental illness. Packaged formats are beginning to be developed that advocacy groups can adapt to meet the particular concerns identified in their focus groups. Education is also media friendly. Newspapers can write stories that challenge the myths. Television can run public service announcements that challenge the stigma in 30-second sound bytes.

Unfortunately, education does not yield huge results in changing attitudes and behaviors. Compared to contact, for example, improvement in stigmatizing attitudes after education is relatively low. In addition, research suggests that immediate positive changes that result from education may not maintain over time. In other words, stigmatizing attitudes return to baseline levels a couple of weeks after education is complete. Thus far, research has failed to show education leads to any significant change in behavior.

Contact among members of targeted power groups and people with mental illness is one of the most effective strategies for changing stigma.

Contact

Contact means arranging interactions between people with mental illness and members of the targeted power groups. This means people with mental illness need to be comfortable sharing their experiences with the illness and with the mental health system. They must also be well-grounded in their own self-worth as a person. Table 17 lists several qualities of contact that enhance its impact.

(1) *Qualifying as mentally ill.* In order for contact to have impact, members of power groups need to perceive the individual with whom they contact as actually being a person with mental illness. In some ways, mental illness is a stigma unlike those that result from ethnicity and gender. The public can look at skin color and body features to determine whether someone with whom they have contact belongs to a stigmatized class related to gender or ethnicity. This does not apply to mental illness. Instead, the stigma of mental illness is in many ways more like that experienced by gay men and lesbians. The stigmatized condition is hidden; people must “come out”

Table 17. Definition of the factors that enhance contact as a strategy for decreasing stigmatizing attitudes and discriminatory behavior.

| Factor that Enhances Contact | Definition of Factor |
|--|---|
| Qualifying as having a mental illness | Telling one's story so the member of the power group does not dismiss the person as never having had a "real" mental illness. |
| Not just contact, but interaction | More than just lecturing at people, actually providing members of power groups a chance to interact, swap questions, and socialize. |
| Interaction as equals | Making sure that the person with mental illness is not presented as a pitiful individual but rather a peer worthy of interaction. |
| Level of disconfirmation of the stereotype | The level to which information presented by the person with mental illness differs with the stereotype. |
| Repeated interaction | One-time contact leads to mild positive change. Repeated contact leads to significant and lasting change. |

to alert others that they are gay. There is, however, an interesting difference between contact with gays and with people with mental illness. Generally, the public tends to believe people when they call themselves gay or lesbian.

People with mental illness who are disclosing their experiences often experience the "for real" effect: "For real! Are you really mentally ill?" The premise (built on prejudice) is that any person who appears interpersonally competent and successful could never have had a serious mental illness. Hence, the person providing contact needs to *qualify* as having a serious mental illness (not just a misdiagnosed adjustment disorder). Typically, this requires some discussion of symptoms, focusing on those consistent with severe anxiety, depression, or psychosis, plus a summary of treatment including hospitalization and medications. Obviously, this kind of discussion can be stressful for some people with mental illness and should not be attempted unless the person is comfortable with disclosing these kinds of issues.

(2) *Not just contact, but interaction.* What is the nature of the contact that facilitates attitude and behavior change? Contact which mirrors natural forms of interaction is likely to yield the best effects. Hence, a lecture setting might be the starting place where persons qualify their mental illness by talking about their experiences. In addition, some form of open give and take is especially necessary to enhance the effect. People from the audience need to be encouraged to ask frank questions. A social hour where more informal interaction is possible also improves contact.

(3) *Interaction as equals.* Interaction is also facilitated when the person with mental illness is seen as a peer. People disclosing during contact need to avoid the

“Tiny Tim” perception that, because of mental illness they are to be pitied and seek the assistance of kindly authority figures. Instead, presenters need to focus not only on the challenges posed by their mental illness, but also on their successes despite the disabilities. The leader of the group who introduces the person as a peer, not a “poor patient,” can also facilitate perceptions of equal.

(4) *Disconfirmation of the stereotype.* Having contact with a person with mental illness disconfirms or otherwise challenges the stereotypes of people from the targeted group. As outlined in Table 18, the information provided in contact disconfirms the stereotype at three levels. Low disconfirmation means interacting with a currently symptomatic and highly disabled person; this kind of contact not only fails to challenge the stereotypes, but actually reinforces them. Consider, for example, that most members of targeted power groups are likely to be more prejudiced against people with mental illness if they have contact with an individual who is acutely psychotic and living on the street. Contrast this to contact with people who highly disconfirm the stereotype. This form of interaction has often been seen in the popular press; famous people coming out of the closet and proclaiming that they have successfully lived with serious mental illness. For example, Patty Duke and Margot Kidder have both made compelling public service programs documenting their struggle with mental illness. The Hollywood film *A Beautiful Mind* recalled Nobel Laureate John Nash’s struggles with and victory over schizophrenia.

Table 18. Examples of low, moderate, and high disconfirmation contact.

| Low Disconfirmation | High Disconfirmation | Moderate Disconfirmation |
|---|---|--|
| A person who is currently overwhelmed by the illness, evidently psychotic, and living on the streets. | A person who has not only overcome the illness but has attained an especially prominent role in society; includes famous people such as Mike Wallace, Rod Steiger, Patty Duke, and Margot Kidder. | A person who has struggled with the illness, but despite its disabling effects, has attained some semblance of success at work, home, and relationships. The ideal example is one’s neighbor or co-worker. |

Research suggests that interacting with people who highly disconfirm the stereotypes may yield some change, but this change is muted by what has been called the Thurgood Marshall effect. When Justice Marshall took his place on the U.S. Supreme Court in 1967, progressives hoped an African American appointed to such a prominent and important position would challenge some of the stereotypes about Blacks. Instead, bigots tended to compartmentalize Marshall’s accomplishment and not apply it to Blacks as a group; “Sure, Marshall might be able to become a judge. But he is not like typical Black people who are...!” A similar effect may be seen for people with mental illness who highly challenge the stereotype. “John Nash might be able to overcome schizophrenia and get a Nobel Prize but he’s not like the typical mentally ill guy who is living on the street.”

Research suggests the best form of contact is with a person who moderately disconfirms the stigma. These are people who communicate that their mental illness was a major life hurdle but, that despite this barrier, they were able to accomplish the typical American dream: regular job, nice and safe housing, and family. The best example of this kind of person is the average neighbor or co-worker. Unlike a famous individual, neighbors and co-workers are just like the target group and therefore more likely to seem relevant.

(5) *Repeated interaction.* One-time interaction can have significant effect on the stigmatizing attitudes and discriminatory behavior of people in targeted power groups. Hence, meeting with people at civic clubs, police roll calls, or medical staff meetings can result in less stigma and more opportunities. However, the real secret to successful outcome is repeated interaction. Research on race has shown that one-time meetings between Whites and Blacks decreases bigotry; however, living next to or working alongside people of color, and the daily interaction this entails, can yield permanent change in prejudice and discrimination. Hence, advocates need to identify ways to follow-up a onetime education program with regular contact between people with mental illness and members of the targeted power group.

Reconsider an issue that is relevant to repeated contact. The stigma that represents people of color is relatively obvious (skin color) while the stigma that represents mental illness is not. Hence, the stigma of race is automatically challenged as people interact with individuals of color every day. Not so with mental illness; a member of a targeted power group might be a next door neighbor of a person successfully living with schizophrenia, or a colleague of a businessperson who has beat bipolar disorder, and never know it. Contact is facilitated, and stigma is beaten, when people come out of the closet and share their experiences with mental illness with neighbors and co-workers. The ongoing and continuous relationships foster a deeper understanding and appreciation for the abilities of people with psychiatric disabilities.

Coming out of the closet is no easy task. The point of this handbook is to discuss how stigmatizing attitudes and discriminatory behavior block life opportunities of people with mental illness. Coming out only puts people further at risk of being victimized by this kind of discrimination. There are, however, several benefits to coming out. Among these is diminishing the prevalence of stigma, finding like-minded people who have withstood similar experiences with mental illness and stigma, and being released from the fear that someone will discover their history. Coming out is not an all-or-nothing decision; the person can decide to come out slowly and strategically, letting a few sympathetic people know first, before announcing to everyone in the neighborhood or at work. Several consumers and consumer groups are already heroes in the effort to come out in order to erase the stigma.

Advantages and disadvantages. There are two major advantages to contact. First, research suggests it leads to significant improvements in both attitudes and behaviors which tend to maintain over time. Second, it is consistent with the philosophy of empowerment: nothing about us without us. People with mental

illness, rather than professional experts, are best able to challenge the effects of stigma.

The greatest disadvantage is lack of exportability, especially compared to education programs. Unlike preparing curricula which can be sent around the country or public service announcements which can be widely broadcast, people with mental illness need to be recruited and their story needs to be framed into the most effective format. Moreover, a curriculum typically does not threaten the experts teaching it, whereas people must come out of the closet and risk disapproval when doing contact programs.

Protest. Sometimes, education and contact do not yield a fast or strong enough impact on stigma; despite efforts to influence power groups, many members of these groups continue to express concern about persons with mental illness and rob them of rightful life opportunities. Other times, opinion leaders or media outlets persist in misrepresenting mental illness. For example, some elected officials play on community fears and attribute neighborhood problems to “those mentally ill homeless.” Protest is a reactive approach that is meant to quickly and pointedly stop stigma by reacting to disrespectful images. It has two components. (1) A moral message that stigma is wrong. One way this is effectively done is through audiovisual presentations that highlight many of the disrespectful images about mental illness perpetuated by the media.⁶ (2) Directions that these kinds of thoughts and behaviors should be suppressed. “Stop thinking and acting that way!”

Advantages and disadvantages. Protest seems to have significant impact on business decisions especially in the media. Consider ABC’s experience with *Wonderland*, a prime-time show about a New York City psychiatric hospital that premiered during the summer of 2000. In the first episodes, people with mental illness were portrayed as shooting several police officers and stabbing a pregnant psychiatrist in the belly with a hypodermic needle. None of these images were balanced with people in recovery who were struggling with their mental illness. Several advocacy groups were angry about *Wonderland’s* message and sent letters to ABC management and to the sponsors of the show. After several weeks of protest, ABC pulled the show from the summer lineup with three or four videotaped episodes languishing on the shelf. Given that each of these unshown episodes cost millions of dollars, ABC opted for the financial loss rather than continuing to risk the wrath of letter writers. Hence, protest seems to be a good strategy for getting groups to STOP perpetuating disrespectful images.

Protest’s effects on attitudes are less clear, however. On one hand, it may foster consciousness raising. People who are the targets of protest approaches acquire a better sense of how stigma issues impact the lives of people with mental illness. Education raises consciousness too but protest accentuates the motivational importance of the issue. On the other hand, research suggests that protest leads to a

⁶ An excellent resource for this kind of presentation in Otto Wahl’s (1995) book, *Media Madness: Public images of mental illness*. (published by Rutgers University Press, New Brunswick, NJ.)

rebound effect. Rather than heeding the protester's call to stop thinking bad things about people with mental illness, many people will experience psychological reactance. Try this easy experiment that shows psychological reactance.

For the next five minutes, do not think about white bears.

Most readers probably now have images of polar bears dancing through their heads. Research shows that the protester's command to suppress a thought actually leads to an active effort to try to keep it out of mind and a higher rate of thinking about the banned topic. In other words, telling a targeted group to stop thinking that people with mental illness are dangerous will likely result in that group more often associating mental illness with violence.

Consequences

Protest might be considered a specific case of a more general class of strategies that address stigmatizing attitudes and discriminatory behaviors; consequences. By consequences I mean the strategic provision of rewards for positive expectations and affirmative actions or punishers for stigmatizing attitudes and discriminatory behavior. Punishers are defined as withholding a reward from a group. Hence, absence of the reward can decrease certain discriminatory behavior. In Lesson 1, the impact of rewards and punishers on the attitude-behavior link was discussed. In brief, it said that this link can be strengthened or weakened by the judicious use of consequences. Table 18 on the next page lists examples of rewards relevant to each of the targeted power groups; advocates might use these for trying to increase positive expectations about and affirmative actions towards people with mental illness. Note that the rewards specifically reflect the nature of the power group; landlords and their tenants, employers as a business, public policy makes getting reelected. Let's take a closer look at how consequences play out within specific groups.

Landlords, as business people, have three prominent goals that might be availed. First, they wish to fill their units with rent-paying tenants. Thus, bad publicity may result in having empty property. Second, they would prefer their apartments to be leased to "good" tenants: relatively quiet people who will not disturb their neighbors and who will not damage the apartment. Progressive attitudes and affirmative actions will assist people with mental illness who live in their property to do so more effectively. Third, they do not wish to be investigated by government agents or other regulators for alleged violations of the Fair Housing Act or other relevant codes. Advocates may get quick response from landlords when threatening appropriate civil action using these codes.

Table 18. Rewards for which members of targeted power groups may change their attitudes and behaviors.

| TARGETS | REWARDING CONSEQUENCES |
|---------------------------------------|---|
| LANDLORDS | Rent-paying tenants Non-problematic renters No trouble from government regulators |
| EMPLOYERS | Paying customers Good employees No trouble from government regulators |
| HEALTH CARE PROVIDERS | Paying patients Treatment-compliant patients No trouble from regulators |
| CRIMINAL JUSTICE PROFESSIONALS | Community support Easier handling of crime situations |
| PUBLIC POLICY MAKERS | Constituent support Party support |
| THE MEDIA | Paying customers |

Employers are mostly business people, too. Hence, they generally do not want to suffer any kind of boycott that will diminish their customer base. The various forms of media are also included here; they do not want to lose readers, viewers, and other patrons. Hence, coordinated boycotts of employers and media that perpetuate stigma and discrimination may be a powerful consequence for reducing these behaviors. Conversely, patronage of employers and media that promote positive expectations and affirmative actions will likely encourage those businesses to continue this kind of progressive action. Employers also seek good employees. Hence, affirmative actions will help them to better partner with employees with mental illness so that the person is better able to perform his or her job. Finally, like landlords, employers wish to avoid legal action that may result from violation of the Americans with Disabilities Act and similar legislation.

Health care providers work for a business that sets annual revenue goals. Hence, these businesses, and the practitioners they employ, seek paying patients who will help them make their revenue goals. They do not wish to suffer a negative image that might drive away patients. Health care providers also seek compliant patients with whom the physician might collaborate in a friendly manner to develop and implement the most effective treatment plan. Finally, health care providers wish to avoid investigations from regulatory groups that are responding to charges of prejudice, discrimination, or other disparity.

Police and other criminal justice professionals seek community support for their work. Among other things, this support results in municipalities appropriating more resources. Moreover, community support leads to alliances between officers and citizens that make handling crime situations much easier. Public policy makers are usually beholden to an electorate. They either are directly voted into office or are

appointed by people who are elected. Hence, public policy makers must have constituent support. This takes the form of people who will support election campaigns monetarily or as a volunteer and who will go to the polls on Election Day. This also includes party support because political parties are very important for the day-to-day operation of American government. Policy makers do not want to alienate large constituencies or their party by taking unpopular or seemingly discriminatory positions. Instead, they yearn for support based on what advocates perceive as affirmative actions.

Organization. Generally, reward represents economic, political, or legal consequences. In some cases, individuals trying to use these consequences may make a difference. Perhaps a businessperson will be responsive to a letter from an individual advocate complaining that continued prejudice and discrimination will lead him or her to stop patronizing their business. This kind of action is much more effective, however, when conducted as a group. Many advocates reading this handbook may already represent a constituency of stakeholders in mental illness and mental health care; individuals in this constituency can be organized into specific economic or political campaigns. Several additional steps can enhance the task of organization.

- Educate people with mental illness and related stakeholders that they belong to a like-minded group which, when organized, can have significant economic and political clout. Gay men and lesbians learned this lesson during the 70's and 80's such that now they are a market and political force with which to be reckoned.
- There are differences in opinion among the range of advocacy groups that focus on mental health care. Develop ways to set aside these differences for specific campaigns that accomplish a goal to which many stakeholders subscribe.
- Educate the public that people with mental illness and other stakeholders have organized into a powerful force. This works particularly well with elected officials.

Advantages and disadvantages. Strategic use of consequences in an organized format can have significant impact on the discriminatory behavior and affirmative actions of targeted power groups. As argued in Lesson 1, consequences tend to have greater effects on behaviors than on attitudes. If attitude change is also necessary, advocates may wish to combine an educational or contact approach with consequences. Perhaps the greatest disadvantage of consequences is the level of organization and coordination required to successfully accomplish it. Frequently, advocates from several different groups need to set aside their differences and unite in a common campaign.

Summary of Change Strategies for the Rational Actor. There are a variety of strategies which advocates might use to change the attitude-behavior link in targeted power groups. As outlined in Table 19, strategies differ in terms of advantages and disadvantages. These costs and benefits will also differ with the community in which stigma change is sought. Hence, advocates need to review the nature of the stigma problem (from the needs assessment and focus group); consider how various strategies might address this problem and play out in their community; and make an action plan accordingly.

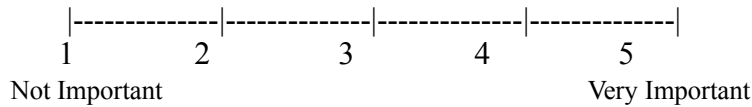
Table 19. Summary of the advantages and disadvantages of four strategies for challenging the attitude-behavior link.

| | Advantages | Disadvantages |
|---------------------|--|--|
| Education | Feasibility: <i>relatively easy to set up</i> Exportability: <i>prepackaged programs that easily can be used in multiple settings.</i> Media friendly: <i>easy to partner with media for mass distribution.</i> | Immediate effect: <i>compared to some other approaches, education does not lead to big changes in attitudes and behaviors.</i> Maintenance of effect: <i>any immediate changes often return to baseline levels.</i> |
| Contact | Efficacy: <i>seems to lead to significant change in attitudes and behaviors that remain over time.</i> Empowerment: <i>the people best suited to counter stigma are individuals with mental illness -- nothing about us without us!</i> | Exportability: <i>not easily disseminated for others to use.</i> |
| Protest | Stop behavior: <i>protest letters that request media to stop disrespectful images can be successful.</i> | Stop attitudes: <i>protest can lead to rebound effects such that stigmatizing attitudes worsen.</i> |
| Consequences | Potent: <i>when used effectively, may lead to significant changes, especially in behavior.</i> | Difficult to coordinate: <i>need broad and united group of advocates to respond in effective manner.</i> |

OTHER CHANGE STRATEGIES

As discussed in Lesson 1, sometimes people in targeted power groups are unaware that they agree with stigmatizing attitudes or behave in a discriminatory manner. Education and contact might help them become more sensitive to these attitudes and behaviors. Nevertheless, unconscious prejudice will remain a problem demonstrated by many members of targeted power groups. One strategy that may help to make the unconscious conscious is called **values self-confrontation**. In this technique, program participants confront their unconscious attitudes about a group. Research suggests that persons are likely to change their attitudes when they find out that, rather than being open-minded, they really stigmatize a group. The task is summed up in this introduction.

Your attitudes about persons with mental illness are strongly affected by your values. In particular, values about freedom and opportunity have a significant impact on the ways you approach persons with mental illness. Hence, the place to begin is to determine your views about basic attitudes in a free society. On a five-point scale indicate the importance of each item for a free society like the United States.



- _____ Equal opportunity for all.
- _____ A chance to pursue your dreams.
- _____ Fair opportunity regardless of race, creed, or disability.
- _____ Respect and admiration for your accomplishments.

Now add up the scores for the four items. The total score represents the person's belief in American ideals related to democracy and opportunity. Top score is 20.

Next ask participants to rank the importance of the following opportunities for people with mental illness living in a free society like the United States.

- _____ To work in fulfilling jobs that pay a living wage.
- _____ To live in the neighborhood of their choice.
- _____ To marry and start a family.
- _____ To enjoy a good time in their community.

Once again, participants add up the numbers for individual items yielding a top score of 20. This total represents the person's support of American ideals for people with mental illness.

Lastly, people compare their perspective on freedom in society and freedom for persons with mental illness. An easy way to do this is by subtracting the "freedom for person with mental illness" score from the "freedom in society" score.

$$\begin{array}{r}
 \text{freedom in society} \\
 - \text{freedom for people with mental illness} \\
 \hline
 \text{difference score}
 \end{array}$$

If they have equal respect for freedom in society and opportunities for people with mental illness, then the difference between total scores should be less than three. However, some people have a much higher "freedom in society" score; these people need to reconcile the difference. How is it that they can be fairly supportive of

freedom for society in general, but willing to limit the opportunities of people with mental illness?”

Many participants who are unaware of their stigmatizing attitudes towards people with mental illness will show big differences between their views about freedom and their willingness to provide opportunities to persons with mental illness. The values self-confrontation exercise clearly illustrates this point. The program speaker should inform people who show big differences across scales that these differences may exist because they believe myths about mental illness. Hence, reviewing these myths through education and/or contact may help them change their attitudes. Some speakers repeat the values self-confrontation exercise at the end of a program to find out whether the two scales are now much closer.

WHAT SHOULD THE MEDIA DO?

Several strategies have been discussed in Lesson 3 about ways which media might join the struggle against stigma and discrimination rather than be a central cause of it. Media should partner with advocacy groups to develop public service announcements that challenge the myths of mental illness with the facts. In response to protest messages, they need to cancel news and entertainment programs that blatantly disrespect people with mental illness. Instead, they should consider developing some stories about people in recovery. Unfortunately, featuring people in recovery does not make for interesting drama or comedy. People in recovery are adults who work, live, and play just like everyone else. This is not particularly entertaining. Rather than omitting people with mental illness from entertainment, they ought to rewrite the roles so that mental illness is in background. There are several examples that illustrate this point.

- When *I Spy* premiered on NBC in 1965, Americans got to know a debonair and worldly crime fighter who happened to be African American, Bill Cosby.
- In *L.A. Law*, the law firm had an honest and able-bodied assistant, Benny, who was also a person with mental retardation.
- On NBC's hit show *E.R.*, lead doctor Kerry Weaver uses a crutch but has never explained why.

In each case, a person who is part of a stigmatized group is presented in a normal, actually heroic light that challenges the stigma of mental illness. A current example of this for mental illness is the television show *Monk*. Originally produced by the USA Network and now aired by ABC, *Monk* stars Tony Shalhoub as a talented detective who also has obsessive-compulsive disorder. Although *Monk* dances around subtle humor related to OCD, it mostly keeps the mental illness in background and features this intelligent hero.

Note: In receiving feedback on an earlier draft of the handbook, several colleagues urged me to put more exercises and vignettes in it. I opted not to however because my goal here was to provide a SHORT overview for the busy advocate. A more thorough discussion of these issues is provided in our book: *Don't Call Me Nuts! Coping with the stigma of mental illness*. By P.W. Corrigan & R.K. Lundin (2001). Tinley Park, IL: Recovery Press. The book is available on Amazon.com.

LESSON 4: MEASURING IMPACT

In all things that are purely social we can be as separate as the fingers, yet one as the hand in all things essential to mutual progress- Booker T. Washington

The goal of mental health services research is to find the evidence that shows specific interventions lead to positive outcomes. This kind of effort sorts out those interventions that have some actual merit versus those which are solely based on good intent. Changing public opinion about and behavior towards people with mental illness should heed the same call. Advocates engaged in stigma change that seeks to expand the opportunities for people with mental illness need to collect evidence that examines its impact. Advocacy groups are typically not research enterprises, however. Recommendations for this kind of program evaluation need to be done in a user-friendly way. Lesson 4 includes specific recommendations for how to measure changes in attitudes and behaviors.

Table 20. Elements of the prejudice directed at the people with mental illness.

| Stigmatizing Attitudes and Prejudicial Responses | Type of Prejudice | Definitions and Examples |
|--|---------------------|--|
| Responsibility | Stereotype | Blaming people for the onset and relapse of their mental illness |
| Pity | Emotional reaction | Over-sympathizing can lead to an authoritarian perspective that can disempower individuals with mental illness |
| Anger | Emotional reaction | As the result of blame, disdaining people with mental illness |
| Dangerousness | Stereotype | People with mental illness are unpredictable and violent |
| Fear | Emotional reaction | As a result of the dangerousness stereotype, being afraid of people with mental illness |
| No Help | Behavioral decision | Withholding neighborly assistance to people with mental illness because they are not deserving |
| Coercion | Behavioral decision | Endorsing mandatory treatments with which people with mental illness must comply |
| Segregation | Behavioral decision | Endorsing treatment in segregated institutions away from the person's community |
| Avoidance | Behavioral decision | Not wanting to work alongside of or live near people with mental illness. |

MEASURING ATTITUDE CHANGE

One of the assumptions of this handbook is that stigmatizing attitudes are a source of many of the barriers to life opportunities for people with mental illness. Many of the strategies reviewed in Lesson 3 were meant to change these attitudes. Hence, measuring attitude change is a forthright strategy for determining whether an anti-stigma program has decreased the prejudice that results from mental illness. In Lesson 1, prejudice was defined as endorsing the stereotypes about a group, emotionally reacting to those stereotypes, and deciding to act accordingly. Table 20 summarizes the specific examples of stereotypes, emotional reactions, and behavioral decisions relevant to mental illness.

The Attribution Questionnaire 27 (AQ-27) is a brief measure of the ideas in Table 20; the Appendix at the end of this Lesson contains the AQ-27. The AQ-27 has been used in more than a dozen studies and has been shown to be a sensitive measure of various attitudes and other prejudicial responses towards people with mental illness. To measure attitude change in a group, administer the AQ-27 before the stigma change program and immediately after. Comparison of the pre-test and post-test scores will show whether the anti-stigma program made a difference. Advocates might also want to repeat the AQ-27 two to four weeks later to determine whether any positive gains that might have been found immediately after the anti-stigma program are still evident at follow-up.

MEASURING BEHAVIOR CHANGE

An equally important goal is to assess whether anti-stigma programs have led to change in behavior. Typically, measuring behavior change is much more difficult than assessing attitude change. It may be inferred from the four sets of items in the AQ-27 that represent discriminatory behavior: no help, coercion, segregation, and avoidance. However, what a person says they are doing, in terms of people with mental illness, may differ from their actual behavior. Accurate measurement may require observing whether members of targeted power groups actually change their behaviors towards people with mental illness. Unfortunately, this kind of effort typically requires more resources than advocacy groups have for program evaluation.

Anti-stigma programs need to assess change in attitudes or behaviors to assess their impact.

One way to assess actual behavior change may be to set up a monitoring committee after the anti-stigma program. For example, members of a civic club might join people with mental illness in an effort to track hiring and reasonable accommodation efforts of employers in their community. Rather than assuming a

watchdog role, this becomes a collegial effort to facilitate work goals for people with mental illness. Moreover, the ongoing contact between people with mental illness and power group members further reinforces positive expectations about individuals with mental illness. During regular meetings, monitoring committee members can set goals in terms of work (or other important issue), discuss progress towards these goals, and plan additional activities that will help them become a reality.

GETTING HELP FROM LOCAL RESEARCHERS

My goal was to simplify the evaluation process so that advocates without social science training could collect reasonably sound data to determine the impact of a specific anti-stigma program. Many communities have a resource that might be a useful partner in testing anti-stigma programs: the local college. Faculty and students at these schools are often looking for places to use their research and evaluation skills. They also frequently include progressive individuals who would appreciate the opportunity to join advocates promoting social justice. Several departments at local colleges might have faculty or students who would be interested in partnering; these include psychology, social work, sociology, anthropology and social science. Talking to colleagues and friends who are familiar with the college may identify suitable faculty and/or students. Alternatively, advocates might wish to “cold call” the chairperson of relevant departments, explain their need, and determine whether anyone would be appropriate to conduct a program evaluation.

APPENDIX TO LESSON 4

Name or ID number _____

Date _____

PLEASE READ THE FOLLOWING STATEMENT ABOUT HARRY:

Harry is a 30-year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He has been hospitalized six times because of his illness.

NOW ANSWER EACH OF THE FOLLOWING QUESTIONS ABOUT HARRY.
CIRCLE THE NUMBER OF THE BEST ANSWER TO EACH QUESTION.

1. I would feel aggravated by Harry.

1 2 3 4 5 6 7 8 9
not at all very much

2. I would feel unsafe around Harry.

no, not at all yes, very much

3. Harry would terrify me.

1 2 3 4 5 6 7 8 9
not at all very much

4. How angry would you feel at Harry?

1 2 3 4 5 6 7 8 9
not at all very much

5. If I were in charge of Harry's treatment, I would require him to take his medication.

1 2 3 4 5 6 7 8 9
not at all very much

6. I think Harry poses a risk to his neighbors unless he is hospitalized.

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

7. If I were an employer, I would interview Harry for a job.

1 2 3 4 5 6 7 8 9
not likely very likely

Lesson 4: Measuring impact

8. I would be willing to talk to Harry about his problems.

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

9. I would feel pity for Harry.

| | | | | | | | | |
|-------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| none at all | | | | | | | | very much |

10. I would think that it was Harry's own fault that he is in the present condition.

| | | | | | | | | |
|----------------|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| no, not at all | | | | | | | | yes, absolutely so |

11. How controllable, do you think, is the cause of Harry's present condition?

| | | | | | | | | |
|-----------------------------------|---|---|---|---|---|---|---|-----------------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all under personal control | | | | | | | | completely under personal control |

12. How irritated would you feel by Harry?

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

13. How dangerous would you feel Harry is?

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

14. How much do you agree that Harry should be forced into treatment with his doctor even if he does not want to?

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

15. I think it would be best for Harry's community if he were put away in a psychiatric hospital.

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

16. I would share a car pool with Harry every day.

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not likely | | | | | | | | very much likely |

17. How much do you think an asylum, where Harry can be kept away from his neighbors, is the best place for him?

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

18. I would feel threatened by Harry.

| | | | | | | | | |
|----------------|---|---|---|---|---|---|---|----------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| no, not at all | | | | | | | | yes, very much |

19. How scared of Harry would you feel?

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

20. How likely is it that you would help Harry?

| | | | | | | | | |
|------------------------------|---|---|---|---|---|---|---|--------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| definitely would not help | | | | | | | | definitely would help |

21. How certain would you feel that you would help Harry?

| | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all certain | | | | | | | | absolutely certain |

22. How much sympathy would you feel for Harry?

| | | | | | | | | |
|-------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| none at all | | | | | | | | very much |

23. How responsible, do you think, is Harry for his present condition?

| | | | | | | | | |
|---------------------------|---|---|---|---|---|---|---|--------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all responsible | | | | | | | | very much responsible |

24. How frightened of Harry would you feel?

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

25. If I were in charge of Harry's treatment, I would force him to live in a group home.

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not at all | | | | | | | | very much |

26. If I were a landlord, I probably would rent an apartment to Harry.

| | | | | | | | | |
|------------|---|---|---|---|---|---|---|-------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| not likely | | | | | | | | very likely |

27. How much concern would you feel for Harry?

| | | | | | | | | |
|-------------|---|---|---|---|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| none at all | | | | | | | | very much |

Scoring the AQ-27

The AQ consists of 9 factors, which are scored by summing the items as outlined below:

| | |
|------------------------------------|-------|
| Responsibility = AQ10+ AQ11 +AQ233 | _____ |
| Pity = AQ9 + AQ22 + AQ27 | _____ |
| Anger = AQ1 + AQ4 + AQ12 | _____ |
| Dangerousness = AQ2 + AQ13 + AQ18 | _____ |
| Fear = AQ3 + AQ19 + AQ24 | _____ |
| Help = AQ8 + AQ20 + AQ21 | _____ |
| Coercion = AQ5 + AQ14 + AQ25 | _____ |
| Segregation = AQ6 + AQ15 + AQ17 | _____ |
| Avoidance = AQ7 + AQ16 + AQ26 | _____ |

The higher the score, the more that factor is being endorsed by the subject.
Note the reversals in scoring items AQ7, AQ16, and AQ26.

SUMMARY: PUTTING IT ALL TOGETHER

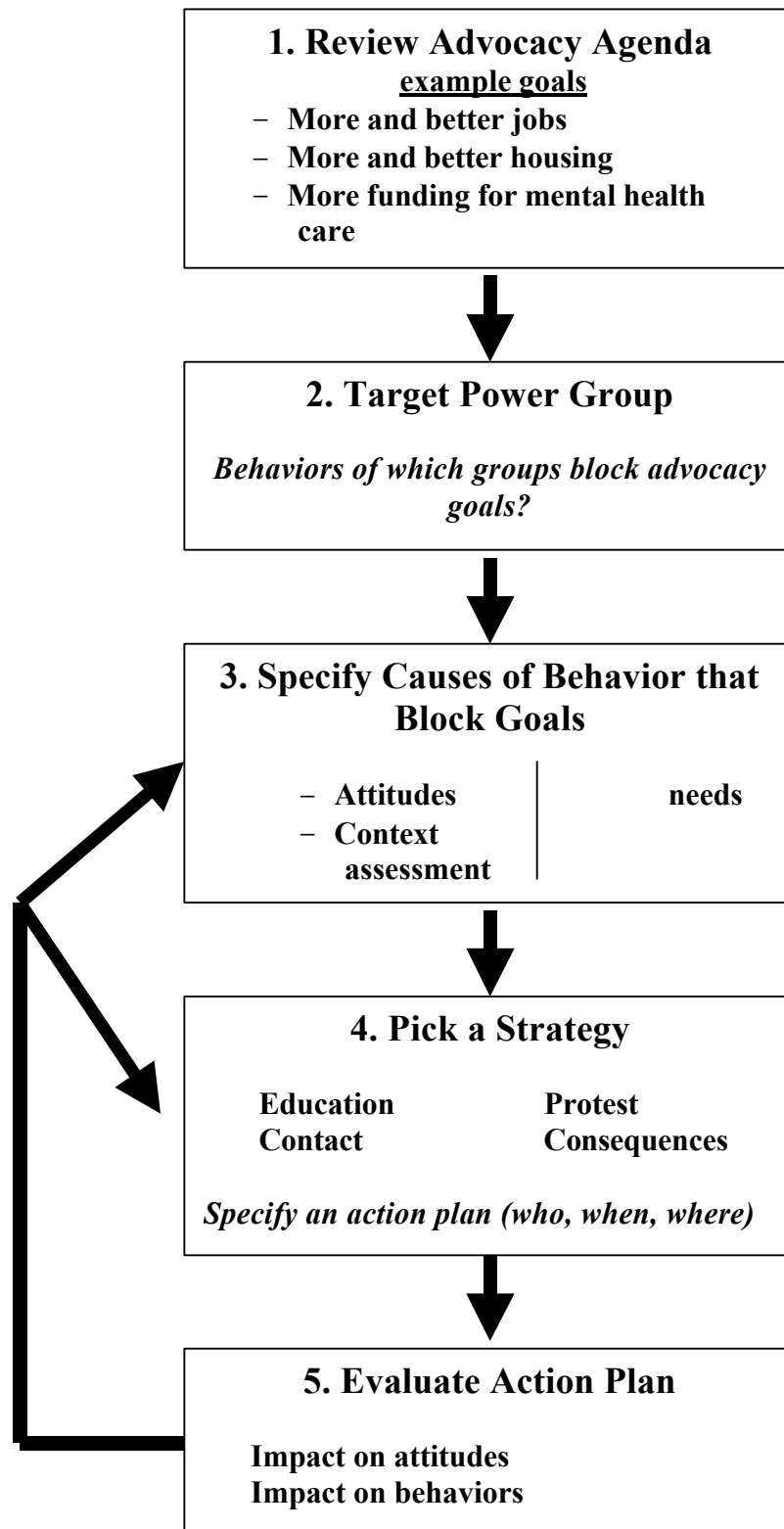
Wherever public spirit prevails, liberty is secure.- Noah Webster

The four lessons provided in this handbook are summarized in the five-step schematic on the next page. After reviewing advocacy group goals (Step 1), the target power group and their behaviors which block these goals are specified (Step 2). Through focus groups with members of the target group and persons with mental illness, specific causes of the behavior are identified (Step 3). Advocates then review the costs and benefits of change strategies in light of the stigma model outlined in Step 3; frequently, they may opt for a combination of strategies. Advocates then develop an action plan that specifies which individuals or groups will be involved, names of target group members, place(s) where strategy will be implemented, and time(s). Step 5 is to evaluate the strategy measuring whether attitudes have improved and/or behaviors changed. In cases where the evaluation showed no positive change, advocates should revisit Step 3 to consider whether their stigma model is correct and Step 4 to determine whether the strategies and action plan are appropriate.

The overall goals of stigma change in order to advance advocacy goals have been summarized as a five-step process.

EXAMPLES OF TWO PROGRAMS

Advocacy groups need to prioritize their action plans, using all that is known about what causes and maintains stigmatizing attitudes and discriminatory behaviors. Since most advocacy groups have limited resources, two combined approaches might offer the best way to challenge the attitudes and behaviors of key power groups: replace the attitude or stop the behavior.



Replace the Attitude

If individuals in targeted power groups had more positive expectations about people with mental illness, then many of the goals blocked by this group would diminish. In particular, landlords who endorse positive expectations about independent living and employers who agree that people with mental illness can be competent workers would lead to a living wage, meaningful occupation, and comfortable housing for many more people with mental illness. A combination of two strategies in Lesson 3 – contact and education – will help achieve these goals when presented to groups of landlords and employers. People with mental illness telling their stories to landlord and employer groups, especially focusing on the myths of mental illness and corresponding facts that challenge them, can have significant impact. Contact effects are further enhanced when the person telling his or her story is actually from the landlord or employer's community. The short-term impact of the person's story is further enhanced if some kind of mechanism for ongoing interaction is formed. For example, the employer group might start an action committee comprising people with mental illness and employers who will work as peers to rectify work disparities in their community.

Attitude Be Damned; Stop the Behavior

Advocates need patience and a willingness to work with targeted power groups in order to get these groups to adopt a more enlightened perspective. Unfortunately, some members of targeted power groups regularly perpetuate such disrespectful and stigmatizing messages about people with mental illness such that the kind of patience needed for attitude change will not suffice. In these cases, a well-coordinated effort at an economic or political boycott is needed. Media outlets need to be told that a sizeable part of their market (people with mental illness and others concerned) will no longer purchase their products or services if specified messages continue. Similarly, elected officials must be informed that members from a sizeable bloc of their constituencies will not provide support in the upcoming election unless certain messages change. Both these approaches are largely reactive, requiring specifically crafted messages to the businessperson or politician that convey group dissatisfaction and subsequent consequences. Advocates need to work now to recruit more people of like mind to join the effort so that their economic and political base will broaden and be in place when protest is needed. Advocates also need to educate the public as to the size and potency of this kind of coalition.

ABOUT THE CHICAGO CONSORTIUM FOR STIGMA RESEARCH

The Chicago Consortium for Stigma Research is a collection of researchers and advocates from the Chicago area. Researchers number more than 30 from ten area institutions:

| | |
|----------------------------------|----------------------------------|
| University of Chicago | Northwestern University |
| Illinois State University | University of Illinois - Chicago |
| Loyola University | Northern Illinois University |
| Columbia College | Illinois Institute of Technology |
| National Opinion Research Center | Thresholds, Inc. |

Researchers represent basic behavioral sciences (social psychology, sociology, anthropology, economics, marketing/media studies), clinical sciences (clinical psychology, psychiatry, and social work), and methodological expertise (quantitative and qualitative design, statistical analysis). Consortium faculty see our jobs as conducting research about stigma, stereotypes, prejudice, and discrimination -- and about effective means for decreasing these processes -- so that advocates have the necessary information to craft anti-stigma programs that best address an agenda that promotes empowerment and recovery. Towards this end, the Consortium also includes the active involvement of several advocacy groups. These include representatives from:

National Alliance for the Mentally Ill
National Mental Health Association
Equip for Equality
Mental Health Consumer Education Consortium
Community Behavioral Health Association
Office of Consumer Affairs, Illinois Division of Mental Health.

Consortium work has been supported by grants from the National Institute of Mental Health, National Institute of Alcoholism and Alcohol Abuse, National Science Foundation, Substance Abuse and Mental Health Services Administration, Boeing Foundation and MacArthur Foundation. More information can be obtained about the Consortium at

www.stigmaresearch.org

Our website includes an “advocates” page plus a list of our publications which can be ordered directly on line. Alternatively, interested parties can reach us at

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More Reading

Further information can be obtained from two books completed by Consortium researchers. Both can be easily obtained on amazon.com.

Corrigan, P.W., & Lundin, R.K. (2001). *Don't Call Me Nuts! Coping with the stigma of mental illness*. Tinley Park, IL: Recovery Press. Written by a researcher and consumer, this book is chock full of handouts, exercises, and specific strategies for challenging the public and self-stigma of mental illness.

Corrigan, P.W. (Ed.) (in press). *On the stigma of mental illness: Implications for research and social change*. Washington, DC: American Psychological Association. This book provides a comprehensive summary of the research from basic social scientists and services researchers at the Chicago Consortium for Stigma Research.

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Let our first act every morning be to make the following resolve for the day: I shall not fear anyone on earth. I shall fear only God. I shall not bear ill will toward anyone. I shall not submit to injustice from anyone. I shall conquer untruth by truth. And in resisting untruth, I shall put up with all suffering. - Mahatma Gandhi

Patrick Corrigan owns the copyright for the material in this handbook. All readers are welcome to copy and/or adapt any ideas, exercises, or handouts directly from the book in order to advance a pro-mental health advocacy agenda.